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THE PEOPLE SPEAK—EXCERPTS FROM REGIONAL
PUBLIC HEARINGS ON HEALTH—VOLUME 5



BUILDING AMERICA'S HEALTH

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A REPORT TO THE PRESIDENT

BY

THE PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION

IN FIVE VOLUMES

Findings and Recommendations—Volume I

America's Health Status, Needs and Resources—Volume II

America's Health Status, Needs and Resources—A statistical appendix—Volume III

Financing a Health Program for America—Volume IV

The People Speak—Excerpts From Regional Public Hearings on Health—Volume V

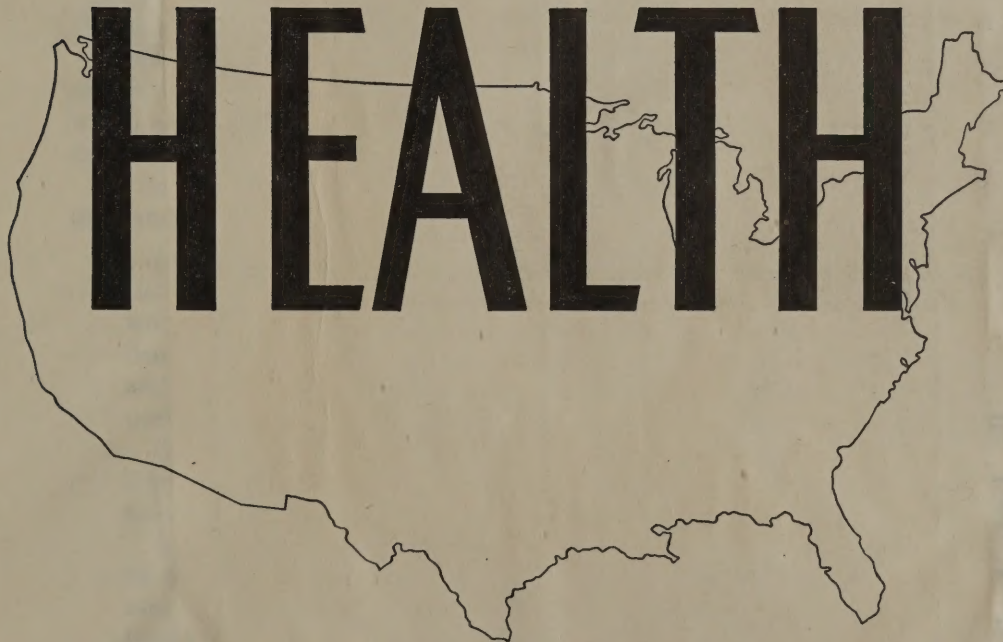


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PUBLIC HEARINGS ON HEALTH—VOLUME 5

BUILDING AMERICA'S HEALTH



A REPORT TO THE PRESIDENT
BY
THE PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION

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ASSIGNMENT FROM THE PRESIDENT

Establishing the President's Commission on the Health Needs of the Nation

WHEREAS our Nation's strength is directly dependent upon the health of its people; and

WHEREAS the needs of our military, defense-production, and civil-defense programs for an assured and adequate supply of personnel and services present special problems in the allocation of our health resources during this emergency period; and

WHEREAS it is essential that at all times adequate provision be made to meet the health needs of the general public, including veterans; and

WHEREAS an objective appraisal of the effect of actions taken to provide for immediate and emergency needs is essential at this time in order that we may continue to meet long-term requirements for safeguarding and improving the health of the Nation:

Now, THEREFORE, by virtue of the authority vested in me as President of the United States, it is ordered as follows:

Section 1. There is hereby established a commission to be known as the President's Commission on the Health Needs of the Nation, which shall consist of a chairman and fourteen other members to be designated by the President.

Section 2. The Commission is authorized and directed to inquire into and study the following:

(a) The current and prospective supply of physicians, dentists, nurses, hospital administrators, and allied professional workers; the adequacy of this supply in terms of the present demands for service; and the ability of educational institutions and other training facilities to provide such additional trained persons as may be required to meet prospective requirements.

(b) The present ability of local public health units to meet demands imposed by civil-defense requirements and by the needs of the general public during this mobilization period.

(c) The problems created by the shift of thousands of workers to defense-production areas requiring the relocation of doctors and other professional personnel and the establishment of additional facilities to meet health needs.

(d) The degree to which existing and planned medical facilities, such as hospitals and clinics, meet present and prospective needs for such facilities.

(e) Current research activities in the field of health and the programs needed to keep pace with new developments.

(f) The effect upon the continued maintenance of a desirable standard of civilian health of the actions taken to meet the long-range requirements of military, civil-defense, veterans' and other public service programs for medical personnel and facilities.

(g) The adequacy of private and public programs designed to provide methods of financing medical care.

(h) The extent of Federal, State, and local-government services in the health field, and the desirable level of expenditures for such purposes, taking into consideration other financial obligations of government and the expenditures for health purposes from private sources.

Section 3. The Commission shall present to the President in writing such interim reports and final report of its studies of the subjects designated in section 2 of this order, including its recommendations for governmental action, either legislative or administrative, as it shall deem appropriate.

Section 4. In connection with its inquiries and studies, the Commission is authorized to hold such public hearings and to hear such witnesses as it may deem appropriate.

Section 5. All executive departments and agencies of the Federal Government are authorized and directed to cooperate with the Commission in its work and to furnish the Commission such information and assistance, not inconsistent with law, as it may require in the performance of its functions and duties; but this order shall not be construed as otherwise modifying the functions or responsibilities of any such department or agency.

Section 6. The expenditures of the Commission shall be paid out of an allotment made by the President from the appropriation entitled "Emergency Fund for the President, National Defense" (Title III of the Independent Offices Appropriation Act, 1952, Public Law 137, 82d Congress, approved August 31, 1951). Such payments shall be made without regard to the provisions of (a) section 3681 of the Revised Statutes of the United States (31 U. S. C. 672), (b) section 9 of the act of March 4, 1909, 35 Stat. 1027 (31 U. S. C. 673), and (c) such other laws as the President may hereafter specify.

Section 7. The Commission shall cease to exist thirty days after rendition of its final report to the President under section 3 of this order, or one year after the date of this order, whichever shall first occur.

HARRY S. TRUMAN.

THE WHITE HOUSE,
December 29, 1951.

THE COMMISSION

Paul B. Magnuson, M. D., Chairman,
Professor Emeritus and Former Chairman,
Department of Bone and Joint Surgery,
Northwestern University Medical School,
Chicago, Ill.

Chester I. Barnard, Vice-Chairman,
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Professor Emeritus of Surgery,
Washington University School of Medicine,
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Albert J. Hayes,
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Washington, D. C.

Joseph C. Hinsey, Ph. D.,
Dean, Cornell University Medical College,
New York, N. Y.

Charles S. Johnson, Ph. B.,
President, Fisk University,
Nashville, Tenn.

Russel V. Lee, M. D.,
Director, Palo Alto Clinic,
Clinical Professor of Medicine,
Stanford University School of Medicine,
Palo Alto, Calif.

Elizabeth S. Magee,
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National Consumers League,
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Clarence Poe,
President and Editor,
The Progressive Farmer,
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Lowell J. Reed, Ph. D.,
Vice President,
Johns Hopkins University and Hospital,
Baltimore, Md.

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President, United Automobile Workers, CIO,
Detroit, Mich.

Marion W. Sheahan, R. N.,
Associate Director, National League for Nursing,
New York, N. Y.

Ernest G. Sloman, D. D. S.,*
Dean of the College of Physicians and Surgeons, a
School of Dentistry,
San Francisco, Calif.

*Deceased.

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Field Assistant

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Jeannette E. Boska
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Elizabeth Dempsey
E. Fay Hall

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Gladys E. Lyons
Marjory Martinez
Nel C. Sera-Leyva
Ann C. Strickland
Virginia M. Stryker

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Beatrice K. Theiss
Raymond R. Wateski
Betty M. Webber
Ida M. Whetzel
Mary T. Young

COMMISSION STUDY STAFF

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Director of Study

W. Thurber Fales, Sc. D.,
Consultant

John B. Grant, M. D.,
Consultant

Margaret D. West,
Biostatistician

Cozette Hapney,
Research Analyst

Meda H. Eliot
Amy W. Firfer
Felix A. Grisette
Elizabeth H. Pitney
William Weinfeld

THE PEOPLE SPEAK

This volume is composed of selections from the testimony of the nearly 400 witnesses who appeared at the eight public hearings held by the President's Commission on the Health Needs of the Nation. During August and September, public hearings were held in Philadelphia, Dallas, Raleigh, Minneapolis, St. Louis, Detroit, Cleveland, and San Francisco.

Although we were pressed for time, we voted to hold these hearings because we wanted to go out to the grass roots and find out what the people were thinking on the big health questions of the day. We invited anyone who wanted to come in and air his considered views at these hearings—we refused to set up a prescribed agenda or a restricted list of either witnesses or topics.

The public outpouring at these hearings exceeded our most sanguine hopes. The good people came in, from the big cities and from the forks of the creek, and they gave us moving testimony of their deep and abiding concern for better health for all. We are deeply grateful to the hundreds of people from all walks of life who testified at these hearings—doctors, labor leaders, ministers, farmers, university officials, Governors, Mayors, housewives, industrialists, medical school Deans, insurance executives, lawyers, health council leaders, voluntary health organization representatives, dentists, nurses, social workers, home demonstration agents and just plain citizens. Many of them travelled long distances at their own expense, since the Commission did not have the funds to reimburse them. We are also grateful to the Governor of North Carolina, the Mayor of Philadelphia, the City Council of Cleveland, and to the public-spirited organizations in other cities for the donation of space for the hearings. Finally, our deepest thanks to the doctors and laymen who served as local chairmen in the various cities—without them, there would have been no hearings.

Although impressive in quantity—the official transcript of the field hearings runs to more than 3,000 pages containing 600,000 words—the bulk of the hearing material is most noteworthy for the high quality and freshness of the individual presentations. We were frankly amazed at the painstaking research and documentation which went into many of the papers, and deeply moved by the very real emotion at the core of many of the eloquent pleas for more and better medical care.

We were deeply pleased, too, that we were able to convince those who were somewhat skeptical of our work that these hearings were an honest, open effort to get at the facts. At several of the hearings, medical leaders who had come with prepared statements highly critical of the conduct of the hearings disowned these statements and praised the fairness of the hearings. We think these public meetings had a tremendous educational value, and we are grateful to the Nation's press for the full and impartial manner in which it covered these sessions.

The selection of the material for use in this volume presented some difficulties, since it was manifestly impossible to include every presentation or the full text of those selected. However, we have increased the size of this volume a good deal beyond our original intent in order to bring as much material as possible before the reader. We had one paramount yardstick in preparing this volume—the people must speak for themselves. We have not changed a single word of the original transcript, and we have resisted all temptations to editorialize.

We have used two broad groupings of material, placing a good deal of it into specific health problem categories and the remainder into sections representing the points of view of large segments of our society—the professional groups, labor, the farmer, the veteran, and so on. We chose this arrangement because it gave us an opportunity to present lengthier excerpts from the testimony. If we had broken the material down into each specific topic discussed at the hearings, it would have necessitated chopping pre-

sentations up and scattering them throughout the volume. We do not contend that the plan of his volume will please all of our critics, but we know that we have given a fair amount of space to each point of view. Where we have had to cut very long presentations, we have tried scrupulously to preserve a continuity of thought.

We feel that this volume is a primer on health, and it fills a big gap in the field. To those who contend that there are no health problems in this country today, we respectfully recommend everything from the table of contents to the last page. To those who want to see some impressive documentation on labor's enormous concern with good health, we recommend the section on the worker's stake in health. To those who want to find out how the doctors and the other professional groups feel on these very same problems, there is a large section devoted to these professional groups. To those who want the pros and cons on health insurance, there is a section devoted to that.

One final note of gratitude. To Mike Gorman, who served as public information consultant to this Commission, goes most of the credit for the success of these hearings. Despite his numerous regular duties with the Commission, he took the responsibility for the field sessions when we made the request of him. His long background in the health field enabled him to work up the over-all plan for the hearings and follow through on the thousand and one details that had to be taken care of. His great faith in the voice of the people and his infectious enthusiasm for the workings of democracy inspired both the Commission and the participants in the field. I can say nothing more appropriate than that this volume is a fitting tribute to Mike's tremendous drive and irrepressible zeal.

In addition, acknowledgement should be made of the work of Mr. Joseph Lubin, who provided valuable assistance in the arrangements of many of the hearings and in the preparation of this volume; and of Mrs. Virginia Shuler, who assisted at the Dallas and Raleigh hearings.

Our debt to the following for their assumption of responsibility as local and panel chairmen for the indicated regional hearings should also be made a part of the record: Mr. Joseph Phillips, Philadelphia, Pa.; Mr. Jerome K. Crossman and Dr. Ozro Woods, Dallas, Tex.; Dr. Frederic C. Hubbard, the Hon. L. Y. Ballentine, Dr. Robert P. Daniel, Major L. P. McLendon, Dr. W. S. Rankin, and the Hon. John W. Umstead, Raleigh, N. C.; Mr. George W. Jacobson, Minneapolis, Minn.; Mr. Donald Danforth, St. Louis, Mo.; Dr. Kenneth B. Babcock, Detroit, Mich.; and Dr. William P. Shepard, San Francisco, Calif.

PAUL B. MAGNUSON, M. D.,
CHAIRMAN.

LIST OF WITNESSES

The following is the complete list of persons and organizations who presented or filed testimony at the regional hearings conducted in eight major cities throughout the Nation by the President's Commission

PHILADELPHIA, PA.

August 11, 1952

Mrs. Arlin Adams,
Chairman, League of Woman Voters of Philadelphia,
Philadelphia, Pa.

Dr. J. L. T. Appleton,
Chairman, Health Division of the Advisory Committee, Health and Welfare Council,
Philadelphia, Pa.

Solomon Barkin,
Research Director, Textile Workers Union of America,
New York, N. Y.

Leonard T. Beal,
President, Southeastern Pennsylvania Association for Mental Health,
Philadelphia, Pa.

Joseph Bicking,
Executive Secretary, Union Organization for Social Service,
Camden, N. J.

Dr. Richard M. Bitner,
President, Pennsylvania Pharmaceutical Association,
Philadelphia, Pa.

Harry Block,
Secretary, Pennsylvania Industrial Union Council, CIO,
Harrisburg, Pa.

Dr. Morris Brand,
Medical Director, Sidney Hillman Health Center of New York,
New York, N. Y.

Dr. William A. Brandt,
Pennsylvania Osteopathic Association,
(Acting President, Philadelphia College of Osteopathy),
Philadelphia, Pa.

Angelo Calisti,
CIO Representative,
Trenton, N. J.

Dr. Elmer B. Cottrell,
Chief, Health and Education Bureau of Instruction,
Department of Public Instruction,
Harrisburg, Pa.

John Cunningham,
Member, Local 447, IUE-CIO,
Federal Telephone and Radio Corp.,
Newark, N. J.

Donald T. Diller,
Executive Vice President,
Medical Service Association of Pennsylvania,
Harrisburg, Pa.

Dr. James B. Dixon,
Commissioner, Department of Public Health of Philadelphia,
Philadelphia, Pa.

James F. Donnelly,
New York, N. Y.

Dr. Gilson Colby Engel,
Surgical Chief at Lankenau Hospital in Philadelphia,
Philadelphia, Pa.

Dr. Glenn S. Everts,
Medical Director, Curtis Publishing Co.,
Chairman, Industrial Health Section of Chamber of Commerce,
Philadelphia, Pa.

L. S. Green,
L. S. Green Associates,
New York, N. Y.

Nicholas Gribaudo,
Guard, RCA,
Member, Local 103, IUE-CIO,
Pennsauken Township, N. J.

Dr. Ivor Griffith,
President, Philadelphia College of Pharmacy and
Science,
Philadelphia, Pa.

Dr. Frederick Herbine,
President, Pennsylvania State Dental Society,
Harrisburg, Pa.

Dr. Catherine Hess,
Medical Director, Philadelphia Division of Amer-
ican Cancer Society,
Philadelphia, Pa.

Naomi M. Houser,
President, Pennsylvania State Nurses Association,
Harrisburg, Pa.

William A. Huff,
Steel Worker,
Trenton, N. J.

Dr. Louis W. Jones,
President, Pennsylvania State Medical Society,
Harrisburg, Pa.

Floyd Kefford,
Chief, Physical Restoration Bureau of Rehabilita-
tion,
Department of Labor in the State of Pennsylvania,
Harrisburg, Pa.

Harry Kranz,
Legislative Director,
New Jersey State CIO,
Newark, N. J.

Dr. F. B. Lanahan,
Medical Director,
Electric Storage Battery Co. of Philadelphia,
Philadelphia, Pa.

Dr. Joseph Langbord,
Medical Director, Sidney Hillman Medical Center
of the Male Apparel Industry of Philadelphia,
Philadelphia, Pa.

Dr. Louis B. LaPlace,
President, Heart Association of Southeastern
Pennsylvania,
Philadelphia, Pa.

Chester R. Leighty,
Executive Secretary, United Neighbors Associa-
tion,
President, Association of Philadelphia Settlements,
Philadelphia, Pa.

L. Lloyd,
National Osteopathic Cerebral Palsy Foundation,
Philadelphia, Pa.

Dr. John P. Looby,
President, Philadelphia County Dental Society,
Philadelphia, Pa.

Isidor Melamed,
The Central Labor Union,
American Federation of Labor,
Philadelphia, Pa.

Dr. Joseph Post,
President, Philadelphia County Medical Society
of Philadelphia,
Philadelphia, Pa.

Dr. Robert C. Prall,
Assistant Director, Child Study Center,
Institute of Pennsylvania Hospital,
Philadelphia, Pa.

Edward J. Pugh,
Memorial Health Center,
Wilkes-Barre, Pa.

Dr. Ella Roberts,
Medical Director, The Children's Heart Hospital,
Philadelphia, Pa.

Dr. Rufus Rorem,
Executive Director, Hospital Council of Phila-
delphia,
Philadelphia, Pa.

William Ross,
International Ladies Garment Workers Union,
Philadelphia, Pa.

Dr. Russell E. Teague,
Secretary, State Health Office,
State Department of Health,
Harrisburg, Pa.

E. A. Van Steenwyk,
Executive Director, Associated Hospital Service,
Philadelphia, Pa.

Charles Warner, Jr.,
Chairman, Division for the Aged Health and Wel-
fare Council, Inc.,
Philadelphia, Pa.

Anthony S. Zuccarello,
Member, Local 731, UAW-CIO,
Trenton, N. J.

DALLAS, TEX.
August 18, 1952

V. M. Ehlers,
Director, Texas Bureau of Sanitary Engineering,
Austin, Tex.

Dr. W. K. Flowers, Jr.,
2317½ Hall St.,
Dallas 4, Tex.

Dr. William W. Frye,
Dean, Louisiana State University School of Medicine,
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Robert B. Glatter,
International Ladies Garment Workers Union,
Dallas, Tex.

Paul Gray,
President, Texas State Industrial Workers Union,
Fort Worth, Tex.

Victor F. Grima,
Director of Industrial Relations,
Texas Manufacturers' Association,
Houston, Tex.

L. Marguerite Hays,
Chairman, Committee Improving Nursing,
Fourth District, Graduate Nursing Association,
Dallas, Tex.

Virginia Huffstetler,
Consultant in Pupil Personal Service,
Texas Education Agency,
Austin, Tex.

Dr. George W. Jackson,
Medical Director, Board for Texas State Hospitals
and Schools,
Austin, Tex.

Myrtle Love,
Dean, Licensed Practical Nursing Association,
Dallas, Tex.

Dr. Chauncey D. Leake,
Vice President and Dean of the Medical Branch
of the University of Texas,
Galveston, Tex.

Moody Moore,
Director, Division of Hospitals,
Arkansas State Board of Health,
Little Rock, Ark.

Pansy Nichols,
Texas Tuberculosis Association,
Austin, Tex.

Dr. Willard Ogle,
Secretary, Texas State Dental Society,
Dallas, Tex.

T. C. Richardson,
The Farmer Stockman,
Oklahoma City, Okla.

Daniel Russell,
President, Texas Rural Health Council,
College Station, Tex.

Dr. P. R. Russell,
Executive Secretary, The Texas Association
of Osteopathic Physicians and Surgeons,
Fort Worth, Tex.

Dr. A. Q. Sartain,
Professor and Head, Department of Psychology,
Southern Methodist University,
Dallas, Tex.

C. D. Scott,
Insurance Executive,
Dallas, Tex.

E. W. Steel,
Professor of Sanitary Engineering,
The University of Texas,
Austin, Tex.

Dr. Allen Stewart,
Regional Chairman and Member, Council on
Rural Health,
American Medical Association,
Lubbock, Tex.

Mrs. Van Hook Stubbs,
President, Texas Federation of Women's Clubs,
Wortham, Tex.

Dick Voyer,
Dallas, Tex.

Dr. L. P. Walter,
State Director of Local Health Services,
Austin, Tex.

Dr. Guy Witt,
Chairman, Department of Psychiatry,
Southwestern Medical School,
Dallas, Tex.

Dr. Ozro T. Woods,
Dallas County Medical Society,
Dallas, Tex.

RALEIGH, N. C.
August 25, 1952

Dr. George F. Bond,
Chairman, Committee on Rural Health,
Medical Society of North Carolina,
Raleigh, N. C.

Dr. Bertlyn Bosley,
North Carolina Home Economics Association.

Dr. E. A. Branch,
North Carolina State Board of Health,
Raleigh, N. C.

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Winston-Salem, N. C.

Dr. R. V. Caviness,
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Mrs. David R. Coker,
South Carolina Woman's Organization.

E. B. Crawford,
Executive Vice President, Hospital Saving
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North Carolina

Mrs. W. K. Cuyler,
Health Chairman of the North Carolina Feder-
ation of Home Demonstration Clubs,
Durham, N. C.

Franz E. Daniel,
State Director, CIO,
Raleigh, N. C.

Dr. Robert P. Daniel,
President, Virginia State College,
Petersburg, Va.

Francis Davis,
Haywood County,
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Graham Davis,
National Commission on Hospital Study,
Chapel Hill, N. C.

Dr. W. C. Davison,
Dean, School of Medicine,
Duke University
Durham, N. C.

Dr. Eugene Dibble,
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Tuskegee Institute,
Tuskegee, Ala.

Dr. R. E. Earp,
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C. A. Fink,
President, North Carolina Federation of Labor.

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North Carolina State College,
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Mrs. H. A. Helms,
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Raleigh, N. C.

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Gardner-Webb College,
Boiling Springs, N. C.

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Member, President's Commission on the Health
Needs of the Nation,
Nashville, Tenn.

Dr. Wingate Johnson,
Bowman Gray School of Medicine,
Winston-Salem, N. C.

R. J. Jones,
Pilot Life Insurance Co.
Greensboro, N. C.

William J. McGlothlin,
Consultant for Professional Programs,
Southern Regional Education Board,
Raleigh, N. C.

Major L. P. McLendon,
Chairman, N. C. Hospital Study Committee,
Raleigh, N. C.

Dr. J. W. Murdoch,
Butner Hospital Alcoholic Rehabilitation Center,
Camp Butner (Granville Co.), N. C.

Marie B. Noell,
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Dr. W. S. Rankin,
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Mrs. O. N. Rich,
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North Carolina Association of Health Education
and South Carolina Society of Public Health
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University of North Carolina,
Chapel Hill, N. C.

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University of North Carolina,
Chapel Hill, N. C.

R. Flake Shaw,
Executive Vice President,
N. C. Farm Bureau Federation,
Greensboro, N. C.

Dr. Norris Smith,
Chairman, Insurance Committee of the Medical
Society,
Greensboro, N. C.

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Representing N. C. Mutual Life Insurance Co.,
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Raleigh, N. C.

Dorothy E. Sutton,
Chairman, N. C. Chapter,
American Association of Social Workers,
Raleigh, N. C.

John W. Umstead,
Chairman, N. C. Board of Hospitals Control,
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Dr. B. E. Washburn,
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Rutherford County, N. C.

D. W. Watkins,
Director, S. C. Agricultural Extension School,
Clemson College,
Clemson, S. C.

Dr. Ellen Winston,
Commissioner of Public Welfare,
Raleigh, N. C.

Dr. Ben F. Wyman,
State Health Officer,
Columbia, S. C.

Dr. David A. Young,
Superintendent, Hospitals Board of Control,
Raleigh, N. C.

MINNEAPOLIS, MINN.
September 2, 1952

Dr. R. G. Arveson,
Chairman of the Council,
The State Medical Society of Wisconsin,
Frederic, Wis.

Charles Bannister,
Arrowhead Health Association,
Duluth, Minn.

Thomas E. Barbeau,
Representing the Townsend Club,
Minneapolis, Minn.

Dr. Robert Barr,
Minnesota Dept. of Health,
St. Paul, Minn.

Oscar D. Berg,
Farmer,
Milaca, Minn.

Dr. R. D. Bernard,
General Manager,
Iowa State Medical Society,
Des Moines, Iowa

Dr. Walter L. Bierring,
Commissioner, Iowa State Dept. of Health,
Des Moines, Iowa

Frances Boone,
Minnesota Chapter, American Association of
Medical Social Workers,
Minneapolis, Minn.

Arthur M. Calvin,
Executive Director,
Minnesota Hospital Service Association,
St. Paul, Minn.

Edwin Christianson,
President, Minnesota Farmers Union
St. Paul, Minn.

Otto F. Christiansen,
Executive Vice President, Minnesota Employers
Association,
Minneapolis, Minn.

Myrtle H. Coe,
President, Minnesota Nurses Association,
St. Paul, Minn.

Merrill M. Cohen,
Vice President, Minneapolis Mental Hygiene
Society,
Minneapolis, Minn.

Lulu Evanson,
State Educational Director,
North Dakota Farmers Union,
Jamestown, N. Dak.

Kenneth Everhart,
Secretary-Treasurer, CIO,
Des Moines, Iowa

John C. Foster,
Executive Secretary, South Dakota State Medical
Association,
Sioux Falls, S. Dak.

Richard Hanson,
County Commissioner,
Court House,
Minneapolis, Minn.

Robert Hess,
President, Minnesota State CIO Council,
Minneapolis, Minn.

Dr. F. J. Hill,
City Health Officer,
Minneapolis, Minn.

K. W. Hones,
President, Wisconsin Farmers Union,
Chippewa Falls, Wis.

Miss R. Idtse,
Vice President, Minnesota State Osteopathic
Association,
St. Paul, Minn.

Dr. W. A. Jordan,
Chairman, Dental Health Education Committee,
Minnesota State Dental Association,
St. Paul, Minn.

Campbell Keith,
President, Minnesota Association of Administra-
tors of Homes for the Aged,
Walker Methodist Home,
Minneapolis, Minn.

John Kelley,
Division of Rural Sociology,
University of Minnesota,
Dept. of Agriculture,
University Farm,
St. Paul, Minn.

Dr. Roger L. J. Kennedy,
President, Minnesota State Medical Association,
Rochester, Minn.

Dr. Karl S. Klicka,
President, Minneapolis Hospital Council,
Minneapolis, Minn.

Dr. Frederic Kottke,
Director, Dept. of Physical Medicine and Re-
habilitation,
University of Minnesota,
Minneapolis, Minn.

J. K. Kyle,
Executive Director,
Wisconsin Association of Cooperatives,
Madison, Wis.

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September 15, 1952

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CLEVELAND, OHIO
September 22, 1952

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Chamber of Commerce,
Cleveland, Ohio

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Part I

THE CONSUMER OF MEDICAL SERVICES

THE WORKER: HIS STAKE IN HEALTH

Statement¹ of
HARRY KRANZ
Legislative Director
Jersey State CIO

I have some familiarity with the problems before the Commission. From the summer of 1947 to last October—a period of four years—I was the State CIO representative on the board of trustees of the Hospital Service Plan of New Jersey (Blue Cross). Since October 1, 1951, I have also been in the CIO as their consultant to the New Jersey Blue Cross plan. However, my remarks today are not on behalf of the Blue Cross but on behalf of the New Jersey State CIO.

* * * *

Blue Cross Plan

Our membership has protection in what we think is the best Blue Cross plan in the country. The membership of nearly 300 of our 400 locals in our Council is now enrolled in the Hospital Service Plan of New Jersey. There are two CIO and two AFL representatives on the 30-member Hospital Plan Board. In ward and semiprivate accommodations in cooperating hospitals, the Plan pays the bill for covered service in full for 120 days and then pays half the daily bill up to \$5 daily for the remaining 245 days of year's hospitalization. The Plan also pays \$5 per visit up to 21 visits by the doctor to his patient in the hospital.

In the case of a subscriber who uses a participating physician and who earns less than \$5,000 per year, the Medical-Surgical Plan pays the full medical and surgical bill during hospitalization.

These are the positive benefits of the New Jersey Blue Cross and Blue Shield plans. There are, however, many deficiencies which these voluntary plans haven't been able to meet.

Voluntary Plans Inadequate: First, their coverage is inadequate. Only about one-fourth of the State's population is enrolled in the Hospital Service Plan of New Jersey. The Medical Surgical Plan has only about 10 percent of the State's population enrolled. As the study by the Senate Labor and Public Welfare Committee disclosed last year, about half the American people do not have any coverage whatsoever—even if all the private insurance company and nonprofit plans are lumped together.

Second, their benefits are inadequate. The private insurance company plans are virtually worthless in the face of constantly rising doctor, hospital and medicine bills. Even the nonprofit Blue Cross and Blue Shield plans cover only a part of the hospitalized illness. They do not provide preventive medicine, including inoculations, periodic check-ups and diagnostic X-rays. They do not cover medical care at home and in the doctor's office. They do not provide lifesaving but expensive "wonder drugs" or appliances.

My experience has confirmed the factual findings of the Senate committee that "voluntary insurance plans do not cover about 80 percent of that portion of the Nation's medical care bill generally regarded as the minimum that is potentially insurable." The Senate committee also found that "less than 3 percent composed of between three and four million persons, have comprehensive medical care insurance, including hospital, surgical and relatively complete medical insurance." The other 97 percent of us demand and are entitled to receive the same kind of protection.

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

Without Government participation, it is obvious that we do not get that kind of protection. Each day new evidence accumulates of the abuses committed by hospitals and doctors against their patients, particularly when it comes to bills, not pills.

Hospital Abuses

Hospital Abuses: Hospitals in New Jersey are continually developing new methods of extorting extra dollars from patients who thought their Blue Cross coverage gave them complete protection. Let me cite a few of these:

1. At least one hospital—Orange Memorial Hospital, Orange—has instituted a \$5 admission fee which it charges all patients, including those with Blue Cross coverage, upon admission. If the hospital, despite its contract with Blue Cross, can charge subscribers a fee of \$5, in addition to the Blue Cross payment, what is to prevent the hospital from raising the admission fee next year to \$10, \$20 or \$50?

2. A number of hospitals in the State not only charge patients extra for cortisone and other expensive drugs, but also charge \$2 and \$3 for each 10-cent dose of penicillin and sulfa. If this trend continues hospitals will soon be charging Blue Cross patients extra dollars for one cent chlorophyl tablets to cure odors.

3. Hospitals not only charge for blood and blood plasma, but even where the blood is donated by a friend or union, the Blue Cross patient in most hospitals finds an extra charge on his bill of \$20 for the blood "set-up," which I presume is the jar and pipe used to transfer the blood from one person's body to the patient's.

4. Some hospitals charge extra for oxygen, and other hospitals charge extra for the administration of the oxygen to the patient.

5. One Newark Hospital—St. Michael's—after receiving payments for covered services from Blue Cross and the balance of the bill from a worker injured in an auto accident, sends the worker a new bill when it finds out the worker may collect damages in a lawsuit for his injuries. The new bill is for the amount of services rendered to the patient under the Blue Cross contract but not fully paid for by the Blue Cross payment.

6. Some hospitals limit their semiprivate accommodations for Blue Cross subscribers, so that a patient with Blue Cross coverage either has to use cheaper ward accommodations or more expen-

sive private accommodations where the hospital is free to charge him an amount in excess of the Blue Cross payment.

Doctor Abuses

Similar abuses exist in the case of doctors and the medical-surgical plan of New Jersey, on which labor has no representation. Let me cite a few examples that come to my attention:

1. If the worker and his family have no insurance coverage, or if they have an indemnity policy, the doctor or surgeon will charge whatever he feels the traffic can bear. The worker frequently does not know how high the bill will be until he receives it in the mail.

2. If he is a Blue Shield subscriber, but if he uses a nonparticipating physician or if he earns more than \$5,000 a year, again the charge will be kept in bounds only by the doctor's conscience. This means that any worker making over \$2.50 an hour in a 40-hour week or over \$2 an hour in a 48-hour week will be confronted with extra charges by his physician—over and above the Blue Shield payment.

3. There is also a disturbing tendency for the family physician who is usually a Blue Shield participant to call in as consultant, surgeon, anesthetist, or X-ray technician a doctor who is not a participating physician. The non-Blue Shield doctor usually charges the patient substantially more than the Blue Shield allowance for the service. Whether he kicks back part of his fee to the doctor who called him in is, of course, a matter of wide speculation.

The Reach of Medicine

Before presenting several witnesses to the Commission, who will present specific testimony on a number of the points I have made, as well as several other points not covered in my statement, I should like to make two additional observations.

First, in listening to the testimony of John Cunningham whose life was saved by a new type of heart operation to correct coronary thrombosis, I hope the Commission will keep in mind the words written by Dr. Lewis Webster Jones, now president of Rutgers University, when he co-authored a study on the "Fundamentals of Good Medical Care" with Dr. Roger I. Lee in 1933. Among other points, he said:

Good medical care implies the application of all the necessary services of modern, scientific medicine to the

needs of all the people. Judged from the viewpoint of society as a whole, the qualitative aspects of medical care cannot be disassociated from the quantitative. No matter what the perfection of technique in the treatment of one individual case, medicine does not fulfill its functions adequately until the same perfection is within the reach of all individuals.

The second point I would like to stress is that while most of the testimony will obviously be concerned with the more dramatic big medical problems and big medical bills, you will also note that the relatively small doctor, drug and hospital bills not covered by Blue Cross or Blue Shield can be and are an extremely heavy burden for a worker to meet, when his income is barely sufficient to maintain a decent standard of living.

* * * *

Mr. KRANZ. As the first witness I would like to present Mr. Anthony S. Zuccarello, who will identify himself further.

CASE HISTORY

Anthony S. Zuccarello

Serious Illness of Wife

My name is Anthony S. Zuccarello. I live at 545 Perry Street, Trenton, N. J., and I am a member of Amalgamated Local 731, United Automobile Workers, CIO. I am presently employed by the New Jersey State Industrial Union Council, CIO. Prior to that I was employed by the Ternstedt Plant of the General Motors Corp. in Trenton, N. J.

I am appearing before this Committee to stress the need for a real national health insurance program to protect the workers who are not covered by any type of health insurance, and if they are covered by this type of insurance to render financial assistance to them so that the individuals will not have to pay out large sums of monies for bills over and above that covered by Blue Cross.

My particular case is in connection with the illness of my wife, who in the latter part of 1949 became ill. Her illness at that time was diagnosed as chronic leukemia. Since that time my wife has needed constant medical attention in order to keep this condition in check. She has been hospitalized at least 15 times and has been transfused over 40 times during this period. I have also had to have medical services for my two children and myself during this same period.

The expenses incurred by me over and above those covered by the Blue Cross during this period are as follows:

In 1949, all of my medical expenses not covered by Blue Cross amounted to \$417.

In 1950, all of my medical expenses not covered by Blue Cross and Blue Shield amounted to \$371.44.

In 1951, medical expenses not covered by Blue Cross and Blue Shield amounted to \$512.86.

Medical Expenses Not Covered

My medical expenses not covered by Blue Cross and Blue Shield from January 1, 1952, to August 4, 1952, are \$941. This includes nursing service in the hospital, hospital services and doctors' fees. This figure is not complete since my wife had to undergo an operation two weeks ago for the removal of her spleen, which if successful, will help her survive. The medical doctor has long since exhausted the 21 visits at the hospital allowed by the Blue Cross and I must pay for all visitations not covered. I am also faced with the payment to the surgeon for the operation, but I have not as yet received his bill.

I have made no allowances for time lost from my previous job, because of visits to hospitals out of the city where examinations were conducted, and also transportation costs. Using these figures I lost approximately 3 weeks of employment, which amounted to \$212 and the cost of transportation amounted to approximately \$60.

The total cost to me since 1949 amounts to \$2,514.30, and I am still faced with an added indebtedness since my wife is still hospitalized, and my benefits covered under Blue Cross are running out.

Savings Exhausted

To meet these expenditures for medical care since 1949, I had to cash all of my war bonds, totalling between \$350 and \$400; I had to use up all of my cash savings, amounting to some \$500; and I had to borrow \$500 from the Local 731 UAWA Credit Union. I am repaying this debt in small amounts, and still owe \$120.

I am reasonably sure that these additional medical expenses which I have paid out could almost be eliminated if we, in this country, had a workable national health insurance program.

I hope, too, that the Commission will recommend an adequate Federal research program so

that we can discover the cause and cure of many of the mysterious ills, such as leukemia, which strike down thousands of Americans yearly.

Commissioner ALBERT HAYES. Thank you, Mr. Zuccarello.

* * * *

Mr. KRANZ. Mr. Chairman, the second witness is a steel worker from the City of Trenton, Mr. William Huff.

CASE HISTORY:

William Huff

Expense of Brain Surgery

Mr. HUFF. Gentlemen, this is a little story of myself. My name is William A. Huff, and I live at 17 Crosswick Street, Bordentown, N. J.

Approximately 10 years ago, my wife began to complain about fierce headaches. There began a series of doctor's visits, not only locally, but a trip to Hot Springs, Ark., and also a year's stay in Reading, Pa. This long period of treatments was very costly, but without success.

Finally, in January of 1952, a local doctor diagnosed the trouble as a head tumor. My wife entered the McKinley Hospital in Trenton, N. J., and was operated on for head tumor in February 1952. After the operation, she had to spend ten weeks in the hospital before she was released. The hospital bill was approximately \$1,400. The hospitalization plan that was carried in the plant paid for half of the hospital bill, and \$200 of the doctor bill. The balance of the hospital bill was paid in full from my savings.

Mrs. Huff is at home at the present time, but must report to the Hospital Clinic three times a week, at a cost of \$5 a visit. The medicine she is receiving costs approximately \$12 a month. The cost of the doctor is approximately \$30 a month. How long this period of convalescence will last, no one knows.

I must say this—I do not have it down here—at the present time I owe the doctors approximately \$900; approximately six or seven of them were called on her operation. On top of that I still owe that much money.

Commissioner HAYES. Thank you very much.

* * * *

Mr. KRANZ. Next is John Cunningham and we can send photostats or newspaper stories which appeared on his now world famous operation.

We do not have clippings with us but those also will be sent to the Commission. He is an electrical worker from Nutley, N. J., living in Newark.

CASE HISTORY:

John Cunningham

Victim of Heart Disease

Mr. CUNNINGHAM. My name is John Cunningham. I live at 109 Seth Boyden Terrace, Newark, N. J. I am a member of IUE-CIO, Local 447, and am employed at the Federal Telephone and Radio Corporation, Nutley.

Although I speak as a C. I. O. member, I feel that I am speaking for the 100,000 or more people who are inflicted with the Nation's greatest killer each year: heart disease.

Up to September 1945 I had been working at Federal Telephone and Radio Corporation as a first-class electrician earning a salary of \$1.47 per hour. I had not lost a day's pay in 21 months.

On September 5, 1945, I reported to work as usual and suddenly I began to feel severe pains in the chest area. On the advice of a doctor I was sent to the hospital, which was St. Michael's of Newark. After 5 days I was sent home with a doctor's advice to see a heart specialist.

Diagnosis of Coronary Thrombosis

The heart specialist diagnosed my condition as a coronary thrombosis. The cost of the examination was \$25 and he ordered me to bed for 6 weeks, during which time I spent about \$20 for medicine and other necessities.

After 6 weeks I made another visit to the doctor at a cost of \$25, at which time he advised me that I had to take a leave from my job for a period of 6 months. The lost time involved in that lay-off was \$1,528; plus \$5 every 2 weeks for medicines, plus \$20 per month a visit to the doctor, or a total cost of \$1,713.80.

After 6 months the company doctor advised that I would have to change my way of living and that I would not be allowed to return to my regular type of work. He was going to refuse to pass me on examination to return to work.

On the suggestion of the heart specialist he agreed to let me return on condition that I had to do light work, sitting down while working and no overtime. Through the help of my local union I was transferred to bench work and classified as a second-class machinist at a salary of \$1.32 per

hour, a loss of 15 cents an hour, or \$6 per week, plus overtime.

From March 1946 when I returned to work until November 1948, when I had my second coronary thrombosis attack, I lost about 30 days because of illness, or approximately \$300 in salary during that time. I made 4 visits to the specialist at \$25 a visit, plus the \$5 every 2 weeks for medicine, or a total cost of \$440.

In November 1948, I was laid up again with a coronary thrombosis attack and this time I lost 2 months' work, at a salary of \$1.47 per hour or \$470.40. If I had been working at my regular trade I would have been getting \$1.62 per hour at this time.

During those 2 months I had one visit at home by the doctor, at which time he gave me an electrocardiograph examination at a cost of \$25, and a visit to his office at a cost of \$25, which included another cardiograph. Total cost for doctor, medicines, and lost time for second coronary was \$540.40.

From the time I returned to work on January 1949 until June 4, 1949, I had very little lost time, but on June 4, 1949, I suffered my third coronary thrombosis attack and was sent back to St. Michael's Hospital for 21 days. The cost for this stay in the hospital to me besides what the Blue Cross paid was \$70 for special medications and other examinations by the doctor, which were not covered by the Blue Cross.

Financial Burden Mounted

After being released by the hospital I was advised to take a leave of absence until August 8, 1949, a total of 9 weeks at a loss of \$529.20 plus medicines and visits to the doctor, at which time he charged me only \$10 a visit for 2 visits, or \$20 plus \$20 for medicines. Total cost for third coronary attack was \$569.20 including lost time, doctor, and medicines.

On August 8, 1949, I returned to work and on August 11, 1949, I had a relapse and had to take another 8 months' leave of absence which cost me in lost time \$2,009.60, during which time I continued to buy medicines but did not have to visit the doctor. Total cost of third coronary attack was \$2,089.60.

I again returned to work on April 15, 1950. From then until January 20, 1951, when I was

operated on for coronary thrombosis, I lost an average of 3 to 5 days a month, or approximately 30 to 35 days in 9 months, or from \$376 to \$439 approximately.

On January 16, 1951, I again entered St. Michael's Hospital, and on January 20, 1951, they operated on me. For 9 days I had to have 3 nurses a day at \$10 per nurse per day or \$30 a day for 9 days. I paid \$270 for private nurses. My total stay in the hospital the first stage of the operation was 12 days. My total cost for the 12 days was \$270 for nurses, plus \$113.50 which included special pharmacy, private nurses' board or \$383.50, which does not include the expenses paid by the Blue Cross.

On February 25, 1951, I reentered the hospital for my second stage of the operation and was operated on February 28, 1951. This time I had 3 private nurses per day for 7½ days, or total cost of \$230, and I was in the hospital 24 days, for which I paid \$122.20 above what the Blue Cross covered, which included special medication and private nurses' board. The total cost to me for the second stage was \$352.20, besides which I had to replace 6 pints of blood or pay \$210 extra.

Worker's Union Assists

Through the cooperation of the officers and members of Local No. 447, I. U. E., C. I. O., I was able to replace the blood by volunteer donors at the rate of two pints for one.

The total cost to me besides what Blue Cross paid was \$735.70 for both operations. The only way I was able to meet these expenses was through the kindness and generosity of the officers and members of Local No. 447, I. U. E., C. I. O. and the members of the New Jersey State C. I. O. Women's League. Between the two organizations they presented to me a total of \$800 which they had received by volunteer donations from their respective members.

Without this assistance, I could never have met my obligations to the hospital.

I should like to point out that the relatively small doctor and medicine bills before my operation amounted to \$854, while the cost to me of the operation in hospital and nursing bills was \$805.70. In other words, it cost me more before the major operation than the operation itself.

To meet my medical bills before the operation, I used up all of my \$300 in cash savings, cashed in about \$150 in war bonds, and borrowed \$200 from the IUE-CIO Local 447 Credit Union.

Beyond the payments made by Blue Cross or Blue Shield, the total cost of my illness to me over a 6-year period has been \$6,852.90. Of this amount, \$5,193.20 represents wages I lost. The remainder, or \$1,659.70, represents direct payments, including \$340 in doctors' fees, \$514 for medicines, \$305.70 for hospital services, and \$500 for private nurses.

Family Doctor Assists

I should mention also that these figures do not include a check for \$1,500 presented to the operating surgeon by my family doctor, in addition to the \$500 Blue Shield paid the surgeon for the operation. I had assumed that the Blue Shield payment would be the full payment to the surgeon and was greatly surprised when I learned of the \$1,500 additional paid by my own physician, apparently out of his own pocket.

In addition to my own personal doctor, medicine and hospital bills, we had to meet dentist bills for my daughter and my wife.

In November 1950 we had to pay \$65 to have my daughter's teeth fixed up and in May 1952 we had to pay \$13 for two visits to the doctor, plus \$4 for medicine because of a gland condition.

In the spring of 1947, we paid \$125 to have my wife's teeth taken care of, which included two plates. And while on the subject, I might add that since I have returned to work after my operation, I have paid over \$50 to cover the cost of 10 trips to the doctor for periodical check-ups at \$5 per visit.

After 4 months of convalescing, I returned to work on May 15, 1952. Since then I have not lost 1 day from sickness and have missed only 4 days for other causes, plus the fact that I have been able to work overtime every week since I returned.

I have been fortunate, but there are hundreds of thousands suffering with this condition who are not as fortunate as I have been. They no doubt would be glad to go through with this operation to be cured if they could afford it, but they can't so they go on suffering, and each year there is another 200,000, according to reports, that are hit with this killer called heart disease.

* * * *

CASE HISTORY:

Nicholas Gribaudo

Kidney Condition

My name is Nicholas Gribaudo, and I live at 4461 Burwood Avenue, Pennsauken Township, N. J. I am 42 years old, work as a guard at RCA, and am a member of Local 103, IUE-CIO. I have a wife and 4 children, ages 16, 14, 10, and 8.

I have been asked to testify before this Commission as a representative of labor.

Since 1947 I have been plagued with medical expenses. Shortly after I was laid off that year I developed a kidney condition and was hospitalized for 3 weeks at that time. My company hospitalization insurance had expired because I was out of work and I could not afford to take it out on a private basis.

My bill was over \$200 for this period of hospitalization. My condition was such that I was not able to return to work until 1950.

During this time I was forced to go on public assistance and my wife and children were supported by Home Life Assistance. During this entire period of 3 years I was averaging an expenditure of \$10 a week on medicine and doctors.

My youngest son has had an ear condition since he was 2 years old, so that even after I myself became better, I have had to continue spending money on doctors and medicine. In 1951 he was operated upon for this ear condition and fortunately the Travelers Insurance at RCA took care of this hospital bill and the surgeon's fee.

However, the operation did not clear the condition up and I had to continue to buy expensive drugs such as penicillin, streptomycin, and aureomycin. In the meantime, my wife also developed this same ear condition, adding to the burden of medical costs.

Wife and Son Undergo Surgery

In June of this year both my wife and son underwent mastoidectomy operations at St. Agnes Hospital in Philadelphia. Travelers Insurance again paid the hospital bill of over \$400 and paid \$125 each to the surgeons for the operation.

However, I have been charged \$500 apiece for each operation, meaning that after the \$250 which Travelers paid I still owed a balance of \$750. Both my wife and son are continuing to see the doctor once a week to date and this costs me \$10 per visit.

I have to return to the doctor myself for a check-up every 3 months and must have an X-ray of my kidneys taken every 6 months, which costs me \$45 and which is not covered by the insurance.

At present I have just had \$40 worth of dental work done and have been advised by my dentist that I should have both upper and lower plates which would cost me \$100 apiece.

My wife also needs a plate and my youngest child needs a dentist's attention, but I am just in no position at the moment to be able to afford any of this dental work.

Home Mortgaged

Before I became ill, I owned my home clear; I have had to mortgage my home in order to meet the heavy medical expenses I have incurred and am now paying off the mortgage.

It will be no gross exaggeration to say that in the past five years I have spent on an average of \$10 a week for doctors and medicine, making an expenditure of \$2,600. Over \$500 in hospital bills, which I have had to pay, or \$3,100, and another \$950, that my Travelers Insurance has paid out, and I still owe the \$750 surgeon's fee for these last operations.

I average approximately \$60 a week, or an annual income of about \$3,100. During this period, of course, I did not work for 2½ years because of my health.

At the rate things have been going, I hardly see how I will ever be able to get on my feet again. My wife is now seriously considering seeking employment, even though she is not physically able to do it, to help augment our income so that we can meet our indebtedness.

Perhaps I have been more seriously beset by illness than the average man with four growing children, but I believe that my experiences point out what medical costs can do to eat away a man's savings, and even then, while working and earning an average wage, prevent him from being able to obtain the medical attention that his family should have.

* * * *

Hospital Abuses in Camden Area

I am Joseph Bicking, Executive Secretary of the Union Organization for Social Service in Camden, N. J., a Community Chest agency. During 1951 we serviced some 5,000 persons in the Greater

Camden area, and of this case load 15 percent dealt with problems in the health field.

Camden is a highly industrialized community and as such the majority of our clients come from the working class of people and a great many of them are referred to us directly by CIO union counselors in the various industries. I should like to present for the Commission's consideration, a brief outline of three cases that we have served during the past year to show how serious illness in a family causes severe hardship and eventually places the family either on an indigent basis or on an inadequate living standard.

These persons were not able to attend this hearing in person to testify, but have given me permission to use their cases with their names withheld.

CASE HISTORY:

Mr. H.

Pneumonia Case

Mr. H., age 39, a married man with 2 children, ages 9 and 2, had worked steadily without any serious illness until December 28, 1951. He had worked at his last place of employment for the past 3 years and averaged \$60 a week. He paid \$45 a month rent and was not able to accrue any savings.

On December 28 he came home ill from work. The doctor was called and he diagnosed the condition as a heart attack and on January 7 Mr. H. was admitted to Cooper Hospital in Camden, where he remained until February 21.

The bill for this period of hospitalization was \$485 and of this his Blue Cross Insurance of Philadelphia paid \$356, leaving a balance of \$129.

After this he was readmitted to the hospital on three other occasions and finally died on March 19, 1952. The bill for his second admission was \$289, his third admission \$75.10, and his fourth admission \$150, leaving a total bill owed the hospital at the time of his death of \$643.10. The only income after December 28 in the family was \$23 a week which his wife received in sick benefits; out of this she could not possibly reduce this hospital bill.

At the time of his death, he had \$2,000 life insurance, one a private policy for \$500, which was used for burial expenses, and the other \$1,500, which the company carried on him. This is the only money that his wife had at the time of his death.

She is now receiving \$114.80 a month in Social Security benefits, hardly an adequate income to maintain one adult and two children a month.

She will, of course, be eligible to apply for Aid to Dependent Children when the life insurance is used up.

When the hospital learned that Mr. H. had life insurance, they demanded that the total balance of the bill be paid out of this money. It was at this point that Mrs. H. sought the assistance of this agency as she had been advised to do by a fellow-worker of her husband's.

Our agency interceded with the hospital and made arrangements with them to go along with Mrs. H. until such time as she had worked out a plan for her family, at which time if she could possibly pay the bill either in part or in full she would do so.

Had the hospital obtained the money at that time, as they no doubt would have done, had she not been advised to seek assistance, it would have meant that she would have been left with a little over \$850 to face the future.

CASE HISTORY:

Mr. M.

Fatal Heart Attack

Case No. 2. Mr. M., age 70, an employee of the New York Shipbuilding Corp., and a member of Local No. 1, Shipworkers Union, was taken to Our Lady of Lourdes Hospital in Camden on February 25, 1951, with pneumonia. Mr. M. was still working at this age because he had never been able to accumulate enough money to retire on.

He had raised six children and in fact was still renting, never having been able to afford purchasing a home.

At the time of his illness, he was earning \$40 a week and was paying out \$55 a month in rent.

He was confined to Our Lady of Lourdes until March 21, 1951, when he was transferred because of the lack of further hospitalization insurance to Lakeland General Hospital, a Camden County Hospital. He remained there until May 17, 1951.

His health insurance, carried by the company, paid all but \$38 of his bill at Our Lady of Lourdes Hospital, but he was billed \$290 for his period of hospitalization at Lakeland.

As soon as he was hospitalized an application for Social Security benefits was made and he and his wife began to receive \$68.40 a month in these.

In addition, he received \$30 a week sick benefits from the company.

At the time he visited our office in August of 1951, he was still unable to return to work because of his health, was visiting the doctor once a week, which cost him \$3 per visit, and was spending approximately \$10 a month on medication.

He came to this office because he was being hounded by the two hospitals to pay his bills, even though he had explained his circumstances to them many times. He did feel that he would eventually be able to return to work and said that then he would attempt to pay these bills.

Our case worker contacted Our Lady of Lourdes Hospital and the County Adjuster's Office, which handles the collection of bills for Lakeland Hospital, and was finally able to get them to agree to an installment plan payment of the bill of \$3 a week on each when he returned to work. Of course, as soon as he returned to work his social security benefits would cease because he would be earning over \$50 a month in covered employment. It hardly seems just, that he should have to scrimp and save out of his meager earnings when he returned to work, which he eventually did, to pay these bills.

CASE HISTORY:

Mr. F.

Cancer Operation

Mr. F., age 56, a construction worker, earning enough to maintain his wife and one child adequately, but not enough to accrue any savings, came home from work on March 15, 1951, very ill.

He was admitted to Underwood Hospital in Woodbury, N. J., on the 17th and on the 19th underwent an exploratory operation. Two weeks later he underwent a major operation for cancer of the rectum (colostomy). He was discharged from the hospital on April 28, and was advised that when he was healed sufficiently, the viscera which had been left on the outside of his body would have to be put back.

During this time he received \$10 a week for 13 weeks from his place of employment, but did not have hospitalization insurance. He then had to obtain assistance from his local welfare department. His wife finally started taking in boarders to help defray expenses, but of course she and the son no longer received assistance.

On September 21 the doctor informed the client that he was ready to have the other operation performed, but that he would have to make the arrangements with the hospital. Before his wife could call the hospital, they called her and told her that before they would readmit her husband, the previous bill of \$760.60 would have to be paid. Fifty-five dollars had already been paid on the bill.

At this point his wife contacted this agency. She said that the Welfare Department would take care of the bill for his second admission but could do nothing about the first bill. This agency contacted the Cancer Society, who said they could take care of \$64 of the bill that was charged for special medicine, but that would be all they could cover.

The hospital was then contacted and they informed our worker that it was lack of bedspace, not the bill, that prevented patient's readmission, and that as soon as a bed were available they would notify the doctor.

However, after 2 months' time, nothing had been done to have this client readmitted, and the doctor informed the client that there were certain rules and regulations beyond his power to manipulate.

Our attorney was then contacted to find out if a hospital could refuse admission to a person because of an unpaid bill, and he pointed out that a public hospital could not, but that this was a privately owned hospital.

Arrangements were then made through the Cancer Society and Cooper Hospital in Camden to have the patient admitted to Cooper Hospital, which was finally accomplished on February 25, 1952.

During this entire period of dickering, the patient's health did not improve because of the constant worry over the bill and the refusal of the hospital to take him back. Had they taken him back when the doctor first said he could return, he would have been able to return to work by the time the second operation was finally performed. He lost approximately \$760 income by the postponement of the operation, just about enough money to pay the bill owed the hospital.

I feel that these three cases point out very vividly a few of the problems incurred by illness and, of course, although at the time of our interviews we did not go into detailed statistics regard-

ing all costs involved in these cases, it must also be remembered that doctors' fees, medicines, et cetera, also had to be paid in addition to the heavy hospital bills.

Statement¹ of E. W. KENNEY

Director Research and Education International Woodworkers of America

I appear before you today in the interest of all lumber and wood products workers—700,000 of them, organized and unorganized.

We are vitally interested and deeply concerned with the problems your Commission is now investigating in all parts of these United States. We are the segment of all employable workers whose occupations, next to mining (and we question this qualification because so many concerns in our industry do not make national reports), are the most hazardous and have the greatest injury and severity frequency rates.

Of the 40 principal industries in this country, lumber ranks fortieth in injury-frequency rate and thirty-eighth in severity frequency rate.

Because the Government has been forced to recognize the hazards in mining, it is actively engaged in policing the safety regulations of that industry. Also with Government approval and support, the United Mine Workers Union now has in force hospital and medical care benefits that are a tribute to the farsightedness of the labor movement in this regard.

For example, in the fiscal year ending June 30, 1952, the United Mine Workers and their families received \$49 million in hospital and medical care benefits. During the same period the International Woodworkers received \$3½ million in benefits.

We cite this comparison to show that although workers in the lumber industry are employed in operations as hazardous as mining, if not more so—although lumber is equally as vital to our national economy as mining—and although we have nearly three times the number of workers in lumber as in mining—despite all these factors, we are not accorded the same Government support that mining is, either from the standpoint of safety or

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

health welfare. We think we are entitled to some consideration in this regard and wish to so state for the record.

Health Hazards in Logging

Among the factors that deprive our people of equal access to adequate care and services are the shortages of resources and facilities and the inadequate coordination, locally, among organizations, institutions and personnel that supply health services.

Logging is more than just a very hazardous occupation. There are additional factors of exposure to all kinds of climatic conditions, insect and animal life, and sometimes even unsanitary living conditions. Much of this environment is beyond the control of the logger and his family.

He lives in small, congested camps adjacent to the logging area, almost completely isolated from society. Such camps are many miles from the nearest physician's office and even many more miles from the nearest hospital. The very barest facilities are available and these leave much to be desired.

All are contributing factors to the health problems of the logger and his family. Medical and surgical attention in such areas is practically nonexistent. When a serious accident occurs on the job or a serious illness breaks out in the camps, the odds are high that death will gain another victim.

Fatalities and Injuries

In the State of Oregon, which is the world center of the lumber industry today, 67 percent of all industrial fatalities in 1950 occurred in the lumber industry—in 1951 it was 55 percent, and for the first 6 months of this year it was 57 percent. During the year 1951 some 60,132 disabling work injuries were reported in Oregon, and 35 percent (21,320) were in the lumber industry. On the basis of these figures you can readily appreciate our interest in having medical, hospital, and surgical facilities near at hand.

Our workers do not have large yearly income earnings, yet they represent one of the hardest working groups of people in the entire working population of this country. Theirs is a rugged, hazardous life. Their employment periods fluctuate considerably and without prior warning, in many cases, due to weather conditions, fires, etc.

Most laboring families in our industry are hard-put to meet the high cost of living in this part of the country. Neither past nor present earnings have afforded these people an opportunity to set aside any money for the "rainy days."

Dependence on Health Insurance

We would like to indicate the degree to which our people are dependent upon health insurance. For the fiscal year ending June 30, 1952, we had an outlay of \$3 million for health benefits. When you stop to consider that this constituted approximately 65 percent of the actual cost to the worker, you can readily perceive the personal burden he must assume out of his net earnings to care for his minimum health requirements, despite the presence of an insurance program.

For the fiscal year of 1952, our workers, covered by insurance, had to pay an additional \$1 million for medical care out of their own pockets. Think what the workers in our industry, not covered by insurance, had to pay out for similar services, in light of these facts.

As a labor union we are doing everything that we can to improve the plight of our workers and their families in regard to health and welfare, but it is an uphill struggle, full of pitfalls, sad experiences and tremendous odds. We have attempted in every contract, with varying success, to incorporate health insurance provisions. At the present time, approximately one-third of our total membership is covered, but this leaves 650,000 organized and unorganized workers in the lumber and wood products industry with little or no coverage.

To us, this is proof-apparent that management cannot be counted on for any strong support in meeting this problem. We, in the labor movement, cannot do it alone—it therefore rests with the Federal Government to take a stand on the matter of health for all our citizenry, regardless of location, regardless of the type of disease, and regardless of patient's ability to pay. For while voluntary insurance plans have given millions of people some insurance protection and helped them to meet hospital and doctor bills, no policy covers the actual cost of surgery, hospitalization, dentistry, home nursing, expensive drugs and such appliances as eye glasses or hearing aids. Any voluntary insurance plan is, of necessity, limited

to what subscribers can afford to pay, and it can never be any other way under the present-day system.

Satisfactory Health Insurance Necessary

To our way of thinking, a satisfactory program of health insurance for our people should provide:

1. That everyone have ready access to adequate health and medical services.
2. That everyone have the kind of service, and all the services, he needs to promote better health.
3. That everyone be able to obtain these without regard for the level of his personal income.

Obviously, these conditions go far beyond the intent of any voluntary insurance plan.

To solve this problem, we believe that the Federal Government should establish a national health insurance plan that will enable all people to receive all the health and medical services they require.

We advocate a national health insurance plan only because we see no other way of bringing adequate medical service to our people. We wish some other program might be devised that would arouse less opposition from many members of the medical profession. But we see none.

EXHIBIT III

U. S. Bureau of Labor Statistics—April 1952 Report of Injury Rates in 126 Manufacturing Industries During Year 1951.

Industries reporting the highest injury-frequency rates¹ for the 12 months of 1951 were:

1. Logging.....	102.6
2. Boat building and repairing.....	57.0
3. Sawmills.....	54.6
4. Planing mills.....	53.3
5. Saw and planing mills integrated.....	51.0
6. Veneer mills.....	45.9
7. Structural clay products.....	40.3
8. Sugar beet.....	40.2

Five of the eight industries listed fall within our jurisdiction—lumber.

¹ Injury-frequency rate is the average number of disabling work injuries for each million employee-hours worked.

A disabling work injury is any injury occurring in the course of and arising out of employment which (a) results in death or any degree of permanent physical impairment, or (b) makes the injured worker unable to perform the duties of any regularly established job which is open and available to him, throughout the hours corresponding to his regular shift, on any one or more days after the day of injury (including Sundays off or plant shutdown).

EXHIBIT IV Oregon Accident and Injury Summary

	Lumber and wood products			All industry		
	First 6 months 1952	1951	1950	First 6 months 1952	1951	1950
Claims.....	9,525	21,320	18,592	27,104	60,132	54,027
Occupational disease.....	81	182	152	374	983	815
Fatalities.....	39	82	104	68	150	155
Frequency rate.....	150.74	155.81	150.98	53.57	58.79	58.01

Source: Oregon State Accident Commission Reports.

EXHIBIT V

A summary of payments made by John Hancock Life Insurance Co. on I. W. A. health and welfare plan for the fiscal year—July 1, 1951, to July 1, 1952.

Accident and sickness.....	\$2,215,321.44
Accidental death.....	315,000.00
Hospitalization.....	312,041.04
Medical expense.....	225,311.90
Surgical benefits.....	141,823.35
X-ray.....	65,112.50
Supp. accident.....	14,656.12
Dependent coverage:	
Hospitalization.....	96,183.59
Surgical benefits.....	60,753.67
X-ray.....	7,234.30
Medical expense.....	5,847.07
Total.....	\$3,459,284.98

EXHIBIT VI

Report on Group Experience

Weekly benefits totaling \$89,153 were paid from July 1, 1950, to March 8, 1952, to employees of the McCloud River Lumber Co., McCloud, Calif., under the IWA-CIO health and welfare plan.

From October 1, 1951, to March 8, 1952 (5 months), medical and hospital benefits totaled \$16,503.

About 84 percent, or an average of 900 employees are covered.

Premium costs were \$134,411, while claims totaled \$128,156. The ratio of claims to premium cost was 95 percent. If this trend continues premium costs will either have to be increased or benefits decreased. This is a good example of what mounting health cost is doing to the majority of voluntary insurance plans today.

Just because some members of the medical profession prefer to maintain the "status quo" on the assumption that "the best of care is already available to all persons," or just because some members of industry prefer to maintain the "status quo" on the assumption that "industry is conscious of the health needs of its employees and is taking steps to fulfill those needs as they arise"—we do not consider such naive remarks sufficient reason to deprive adequate medical services to 70 million people, the majority of whom have ideas differing from those of the American Medical Association and the National Association of Manufacturers about the present day sufficiency of medical services both at home and in industry.

Commissioner **RUSSEL V. LEE**. I have just one question before you leave, Mr. Kenney—about your accidents.

In what agency do you think the matter of accident prevention should reside? Should that be Public Health Service, voluntary unit, or what?

Mr. **KENNEY**. I think that it should incorporate two things. In Canada it is very definitely in a Public Health Service, and there isn't any camp that starts an operation in Canada, regardless of how small or how large it is, that doesn't have within it a man who is highly qualified in taking care of health needs. He is not a doctor, but he has to be similar to a pharmacist's mate on a ship. If an appendectomy is necessary in these camps that are four or five hundred miles up, he can take care of it.

That is in Canada, of course. That is not our particular problem, but I am just pointing out to you some of the problems that we do have. They insist that a man of that type, highly qualified, be at the camp at all times, regardless of whether there are only five men in that operation or 1,800 men.

As far as the other part of it is concerned, I think it is a safety problem and should be set up as a separate bureau within the Bureau of the Interior, or something like what mining has for their own safety. I think it is a joint problem, probably more a problem of safety than medical to a great extent.

But, regardless of everything we try to do, we eventually keep working back into all of these various accidents, and when we have difficulty reaching a doctor—there are many cases where we

have to leave the person right there on the job with a serious accident, not able to get him into town, and he dies on the job. That is not unusual at all, because we sometimes have to go five or six miles with a cat before we get to a railroad, and go another eight or ten miles, and then sometimes by boat from there. It is absolutely an impossibility, and if the situation looks bad they cover the man up and he is left there to die.

Commissioner **DEAN A. CLARK**. Mr. Kenney, the small local hospitals to which you bring these accidents, do you think that they should have surgeons there, highly specialized enough, to take care of these serious cases? These are in rural areas?

Mr. **KENNEY**. Yes, these are in rural areas.

Commissioner **CLARK**. And you feel that there should be men who are well trained enough to take care of these serious accidents?

Mr. **KENNEY**. Yes, because the ones that come in there are really serious. They are types that by the time the man reaches there, even if they were handy, the loss in blood and the crushing of bones, and all that sort of thing, would certainly require that they receive competent attention.

Commissioner **CLARK**. We must realize that the local general practitioners and surgeons really have to do the work. Is that right?

Mr. **KENNEY**. Yes, that is right.

Commissioner **LEE**. Wouldn't the helicopter help your problem out up there?

Mr. **KENNEY**. Yes, it would. The Coast Guard does a great deal of work for us in that respect, and they save many lives in that way.

Commissioner **CLARK**. But there are some areas where you have some emergencies and you might have to have men locally rather than call on transportation?

Mr. **KENNEY**. Yes. Our big problem, as I say, is with the small outfits. You don't even know they are there. They go up and make a killing, and get out. And they don't have any facilities for hospitalization, or anything. So, consequently, if something happened there we wouldn't know where to send people to give aid. But in the big operations, where they see that such care is needed, the Coast Guard is notified as to where their major operations are at all times, and in that way, of course, we can meet the problem.

Statement¹ of

MR. JACOB CLAYMAN

Secretary

C. I. O. Council

Columbus, Ohio

I am secretary-treasurer of the Ohio CIO Council, an organization which represents approximately one-half million CIO members in the State of Ohio.

I do not want to unduly generalize concerning the health needs of the Nation. I am sure that your commission has already been exposed to the over-all picture of the Nation. It takes no research expert to know that a sound job of preventive medicine is supported because too many of our citizens cannot afford regular and thorough medical check-ups.

It is axiomatic to observe in many parts of our country we are understaffed in regard to doctors. It is crystal clear that adequate medical care during sickness is beyond the reach of a large segment of our population.

However, I want to talk a bit about specific situations which have come to my knowledge. Knock on almost any door where workers live in Ohio and you will find multitudes of heartbreaking cases in which a man and a family have spent their life's savings, foregone opportunities for education and all the rest because a major sickness or disease has struck the family circle.

That kind of occurrence is unhappily commonplace in our country and is among workers in particular. I have incidentally brought along with me Mr. Arthur T. Harris of Columbus who has kindly consented to come here and tell his particular story today and I shall not amplify further on this type of common American tragedy.

Now then to the specifics. I have often heard the allegation that most union people have no rightful complaint concerning medical care; that they have been succeeding in arranging with employers for proper and sufficient medical attention and because this is a routine observation I simply took a test case. I took one local union in Columbus; the picture, I am sure, will be reflected all over the State, and I made inquiry. I checked with the United Steel Workers Local Union 2173

which represents workers of the Timken Roller Bearing Co. in the city of Columbus.

Insuring Medical Costs

The Steel Workers Local Union and the Timken Co. have a contract which provides for hospitalization, surgical benefits, sick and accident life insurance. The insurance company involved is the Ohio Medical Indemnity Co. and the program is administered by Blue Cross and Blue Shield.

"Was this program adequate?" I asked the local union officers. And their answer was an emphatic no.

Even though the program actually is better than many and as good as most, that is the case.

They cited a series of specific instances and I jotted them down. I can only give you just a few.

CASE HISTORY:

Walter Jones

No. 1. Let's consider the case of Walter Jones; although it is a kind of common name, I assure you this is a specific individual and address and that sort of thing can be given to the commission if they desire it.

He was operated on in July of this year, opening of the nasal passage. The surgeon charged \$275; the medical program only paid \$90. You see in this situation the existence of as-good-as-average surgical benefit program was of little help to Walter Jones.

CASE HISTORY:

Charles Strait

The problem of Charles Strait of Columbus is even more disturbing.

He likewise is a member of the United Steel Workers Local 2173 and amenable to the union management medical agreement.

In the early part of this year he and his sister, his sister not being covered, had surgery performed upon them. The operations were exactly the same. There were no complications in either case.

The operations were performed in the same hospital, the same doctor performed the surgery on both Mr. Strait and his sister.

Now here is the point of the story. The doctor charged Charles Strait \$100 more than his sister. You see Mr. Strait was subject to a medical program and his sister was not.

¹ Delivered at the regional hearing in Cleveland, Ohio, September 22, 1952.

CASE HISTORY:

Earl Cappel

Or, consider the case of Earl Cappel of Columbus, and likewise a member of Steel Workers Local Union 2173. He reported to the local union officers that his wife was operated on for some female difficulties; the doctor's charge was \$275; the medical program paid only \$150 of this charge. They had many more of these situations. I simply took just a few to trim them to the demands of your time.

* * * *

I do not have to go outside my own experience to mount up this story. In our own office in Columbus we have a similar program which the office maintains for the personnel. About 2 or 3 years ago, I had a bit of a fatty tumor on the back of my back and this comes from personal experience. The doctor charged \$75 and I got \$10 from the medical program. My guess is, though I am not a surgeon, the doctor did not overcharge me. I felt satisfied with his charge. But don't you see the complete inadequacy of these programs in existence in terms of the realities of medical costs today?

Well, the recitation of these experiences can be stretched into hundreds of thousands yearly over the country. They demonstrate that our much vaunted present voluntary medical programs fail to measure up to the realities of modern medical costs.

Rehabilitation of the Injured

And now a subject close to my heart—I have been working on this for a number of years—the subject of rehabilitation of injured workers.

One of the problems which gravely concern us in the field of health is the rehabilitation of industrially injured workers. The plain fact is that as of this moment we in Ohio have pitifully inadequate facilities to bring aid and succor to the armless, the legless, the worker with an injured spine, and all the usual severe industrial disabilities which can and do befall the Ohio worker.

In Ohio the handicapped worker is pretty much left to his own devices and his own fate. He can receive the weekly workmen's compensation pitance allowed by law but beyond that he takes the hazards of the future strictly on his own.

Rehabilitation: A Case History

If you will pardon me and I hope that this will not be considered subversive—if you will pardon me for making reference to a Canadian experience because some of us spent a little time in Canada looking over their rehabilitation program—I can recall visiting the rehabilitation center for the Province of Ontario which is housed on the outskirts of Toronto, Canada. I am thinking of one of the workers I saw there, because maybe we should get a picture of what can be done in this field and it might give us inspiration to do a similar kind of job.

He had lost one leg in a terrible factory accident. His right arm was completely gone, almost to the shoulder, and all the fingers on his left hand were missing. Add to that two broken spinal disks and this unfortunate fellow was hardly more than an animated corpse. He was taken into tow by the Ontario Rehabilitation Center, given an artificial limb and a long course in training to familiarize him with its use.

He was given the usual physical therapy and a thorough course in salesmanship. Every effort was made to pump morale and confidence into this terribly crippled worker. All of this was done with the cooperation of the man's faithful wife and an indomitable will. This cooperation has made this victim of the machine one of the most productive insurance salesmen in the Province of Ontario, and I had the privilege of meeting him up there a couple of years ago.

I can recall the strapping young miner—he was about 6 feet 2 and 210 pounds of sturdy bone and strong muscle. He was athletic and participated in Canadian football, soccer and the rough-and-tumble of Canadian sports. Then came the awful day that befalls a lot of miners in Canada as well as America when the coal caved in and he came out of it missing his right leg. It was a terrible shock to this husky miner, full of the juice of health and with an overflowing boyish spirit for playing in the field.

Again the Ontario Rehabilitation Center came to the rescue.

Patiently they restored his will to live. Slowly they proved to him he could work and earn a livelihood; that living could still be fun with an artificial appliance for a leg.

Now that Canadian miner is again working underground; he is married and giving every evi-

dence of having found living tolerable. This is human salvaging, and it is not mock sentiment, of the highest and noblest order.

Rekindling a Girl's Spirit

I can still remember the little French-Canadian girl. She worked in a Canadian shop and lost a hand in the knives of a machine. Her whole world came crashing down upon her. A man might get along without an arm. Somehow people have come to accept that; but a girl; what kind of life was there left for her?

The Ontario Rehabilitation Center took her in but her progress was very slow. The unfortunate girl had not only lost her hand; she had lost her faith in her personal future. Life had become a complete failure to her, almost before she got to full stature. The people of the Center were tenacious. At long last she commenced to show interest in weaving and basket making. The nurses even taught her how to rouge her lips and make up her face.

The spirit to live was rekindled, and then followed courses in stenography which she successfully concluded and is today holding down and competently filling a good stenographic position somewhere in Ontario. I had the pleasure of meeting her a couple of years ago.

Of course, this kind of thorough and wholesome rehabilitation took trained personnel, it took buildings and equipment. For example, when I was there, the Ontario Rehabilitation Center had 70 physical therapists, occupational therapists, doctors and nurses and maintenance personnel. They took care of the needs of an average patient population of 250.

They had gymnasiums, carpenter shops, recreation centers and a variety of other buildings serving the needs of the handicapped worker.

Rehabilitation Needs in Ohio

In Ohio we have virtually nothing of this nature. There are a few hospitals which can handle a half dozen workers or thereabouts but these do not more than scratch the surface of our needs.

At Ohio State University a program is about to start. I have hopes for it. But it will be years before this new program can do more than handle a dozen or more handicapped.

The plain fact is that while there is much talk about rehabilitation in Ohio there is virtually none in operation.

For example, in 1949 the great State of Ohio spent \$204,881 on vocational rehabilitation. This pitiful sum to be used to provide rehabilitation is like draining the sea with a thimble.

To digress, the last time I checked, we had 103 people serving as full-time game wardens. We spent more money in attempting to rehabilitate and preserve animal life in Ohio than we spent on the whole desperate human problem and economic problem of rehabilitation of workers.

The need for rehabilitation centers patterned after the Ontario program is imperative in Ohio and in virtually every other state of the Union.

While I have discussed only the rehabilitation problems of the industrially injured and handicapped the complaint I have made applies with equal validity to the non-industrially injured and handicapped. They, too, deserve a fair chance in life.

The general point I make is emphasized by the Ohio Program Commission report of Committees on Rehabilitation. I am quoting from that report:

The number of disabled in Ohio apparently in need of rehabilitation ranges between 78,000 and 94,000. In 1949 only eight percent of the need was met in Ohio. There are some areas in the state that have no facilities for rehabilitation purposes. In some areas in which facilities do exist they are not being used for the purpose of rehabilitation. There is great need for organized coordination of existing facilities.

Ohio stands very low in comparison with the other states and territories in vocational rehabilitation. There is a woeful lack of both professional and public understanding of the problems and the value of rehabilitation. There is in Ohio no independent and self-contained law for the conducting of rehabilitation programs. Should Federal legislation or appropriations fail to materialize, the Ohio program would have no provision for continuance.

Medical Attention

Ten minutes is not much time to portray the picture of life lost because people could not afford the cost of proper medical attention; the story of crippling disabilities throughout a whole lifetime because rehabilitation was not available; of poverty and lost opportunities because sickness took the family's life savings. But it does not take an expert or a magician to sense our national shortcomings in the field of health.

Ask most any citizen of Ohio or of these United States and the answer will come out clear.

In my written statement I have made no observation to the President's health program, but as

I sat here listening to the observation of one or two of the doctors—and I gathered from their declarations to this Commission that there is no problem at all in terms of medicine and adequacy of doctors and all the rest in the country—I felt constrained to make this observation. I now am more certain than ever that the medical profession needs some assistance from the general community to carry out a program of adequate care for everybody. And because I make that observation, I conclude by saying that in the humble judgment of people I represent and my own personal judgment, the greatest step forward we can make in America to care adequately for our people in the field of health and welfare and medicine is the institution of the President's program.

So that there will be no notion that this program is purely a product of Washington, to be thrust upon and imposed upon the rest of the people, I want the record to show that the people of Ohio—at least the people I represent—have time and time again observed that they stand behind and for the President's program and are not worried about political slogans or catch words; they are worried about adequate health measures.

Commissioner ELIZABETH MAGEE. I would like to ask you a question about rehabilitation. Could Ohio use more Federal money if we made plans and appropriated money?

Mr. CLAYMAN. Yes, the program of Federal rehabilitation and State rehabilitation is based upon the principle of matching and the Federal Government also provides the office facilities, the administrative facilities for the various States, and so there would be more money available for the State of Ohio if the State of Ohio would appropriate more.

Incidentally, the figure in Ohio does not match up with the great bulk of the States of the Union. We are 'way down at the bottom of the list. I would still make the point there is an inadequate appropriation in the other States, as well as Ohio.

Statement¹ of

MR. ARTHUR HARRIS

Steelworkers Union of
Columbus, Ohio

I am Arthur D. Harris. I am employed by the Columbus Forging Co. as a job setter, a factory

worker. I came here today to demonstrate by my own experience some of the problems that befall the ordinary worker in the factory.

I was married in 1922 at the age of 17—rather young, but I have never been sorry for it. I married a woman who happened to be very thrifty. However, during the course of the years from then on to 1932, holding various jobs, I did not have much opportunity to save any money.

Wife Contracts Serious Illness

It was in 1932 when I was driving a taxicab in Columbus, Ohio—making fairly good money at that time even though it was the depression—that my wife after a serious siege of pneumonia was told by her family physician to visit a lung specialist because he had a suspicion she had tuberculosis.

We had no hospitalization in those days and going to a lung specialist meant quite a bit of money. She went to a lung specialist and after an X-ray and intensive examination she was told she had tuberculosis.

Being alarmed and after having been told once myself that I had tuberculosis, we were not satisfied with one lung specialist so I took her over to the Tuberculosis Society. After an examination by the Tuberculosis Society she was informed her tests were negative and she did not have tuberculosis. That meant going back to the specialist there at considerable expense and telling the specialist that she did not have tuberculosis, that is according to the diagnosis of the Tuberculosis Society.

He said his diagnosis, so far as he was concerned, was the only thing he could say.

Diagnosis Uncertain

So we went to another specialist. He said she did not have tuberculosis but he did not know what she had. So after four or five trips to different specialists my wife decided that was as far as she wanted to go and she was going to let it go. So during the years between 1934 and 1940 she was pretty fortunate in not being very sick. That is, she was sick at times.

In 1940 she became very seriously ill. Calling the neighborhood doctor in and after getting her on her feet, he sent her to a specialist to have her X-rayed.

At that time I was working at the Columbus Bolt & Forging Co. We had hospitalization insur-

¹ Delivered at the regional hearing in Cleveland, Ohio, September 22, 1952.

ance which paid \$4 a day with either \$20 or \$24 for incidentals.

He sent her to be X-rayed, which we had to pay for, the hospitalization did not cover that. He took the X-ray to Ohio State University and after consultation there came to the conclusion that she had bronchiectasis, which he informed us at that time was a very rare disease.

He decided then he would give her a certain treatment. Not being a doctor, I do not know what he hoped to accomplish except what he told me. After about 6 months he was called into the army. He referred us to another specialist with his diagnosis and we went to the specialist. The specialist did not agree with his diagnosis and insisted that she had tuberculosis. My wife, feeling then that she did not have tuberculosis, quit going to the specialist and we were up a stump and did not know what to do.

War Permits Some Saving

We had during the war period after 1940 managed to accumulate \$2,000 in the bank after working 7 days a week—two shifts a day a lot of time. In 1943—the early part of 1943—a friend of ours who had been doctored for her lung, sent my wife to her doctor. This doctor gave her an examination and gave the diagnosis that she had trouble with her blood and recommended certain shots for her blood.

At a cost of \$45 a week all summer he did not help her any. Then seeing a pin on her lapel which was a large pin, an Auxiliary to a lodge that I belonged to, he asked if I belonged to this lodge and she said yes.

"Well," he said, "I think your case is a little bit too tough for me. I will take you upstairs."

So he took her upstairs to another specialist who gave her an examination that cost \$125, ordered her into a hospital for an experimental treatment with penicillin, which at that time had just come into existence. She took 20 shots of penicillin at \$22 a bottle. I understand there are six shots in a bottle. My hospitalization paid \$4 a day and \$20 for incidentals—didn't nearly cover that first expense.

Hospital Bills Mount

Every 3 months for the next 3 years she went into the hospital. The amount of shots she took increased from 20 shots to 250 shots as a treatment. The last two times she was in the hospital, the first

time for 30 days—that is the next to the last time was 30 days—her hospital bill ran \$970, of which my hospitalization paid \$144.

The last 40 days she was in the hospital it ran eleven-hundred-some-odd dollars. Eight days of that was for streptomycin which cost me \$60 a day. We spent the \$2,000 we had saved.

She died two weeks after she came home from the hospital. I was \$2,000 in debt.

Now I have come here not for sympathy, but to tell one workingman's problems in the inadequacy of hospitalization insurance in the hope that something can be done to eliminate the many cases similar to mine that are happening to workmen every day.

Statement¹ of PAUL GRAY President, Texas State Industrial Workers Union Fort Worth, Texas

Unions have found that health security is a matter of basic concern to the worker and his family. The concern of workers to have their health needs met has been demonstrated by their willingness to forego wage increases, to agree to deductions from their pay, and to strike, if need be, in order to secure a satisfactory measure of protection for themselves and their families.

The phenomenal growth of voluntary health insurance plans is an unmistakable sign of the determination of working people in America to secure protection as a matter of right against unpredictable health cost. Thus in a period of three years, some six million workers and over twelve million dependents were newly enrolled for group hospitalization protection largely under negotiated health insurance plans—an unprecedented expansion of family health security.

In one of the larger CIO affiliates, there is a special effort during negotiations with management to reach a better understanding toward the worker and his family's health needs. Since the middle of 1948, the United Automobile Workers has negotiated prepaid hospital-medical protection covering over three million members and their dependents—more than a million workers and two million dependents.

¹Delivered at the regional hearing in Dallas, Tex., August 18, 1952.

It should be known that benefits paid in 1951 under health security programs negotiated by the UAW amounted to more than \$125 million. Of this total, \$50 million was paid for hospital services, \$23 million for physicians' services, a total of \$73 million; and \$52 million was paid in cash income maintenance and life insurance benefits.

Existing Programs Fall Short

While these are indeed impressive totals, we are fully aware that existing programs fall short of adequately meeting the needs of workers for comprehensive health security. Under most existing programs for hospitalization insurance, standards for benefits have been fairly satisfactory, particularly in the industrialized areas where the strength of collective bargaining has promoted higher levels of protection. Provision for labor representation has been made in some industrial areas, thus giving voice to an important purchaser of health insurance.

In the less industrialized areas, however, insurance carriers have not provided the same benefit standards, and we find the worker is forced to pay more out-of-pocket for his hospital care. Drugs are not fully paid, room allowances do not meet the full costs, certain conditions are excluded. For workers who incur chronic or long-run disabilities or diseases, there is very little protection afforded. He must turn to the Government programs for his care, and these programs are of doubtful effectiveness, typically operated on a demoralizing charity basis. The exorbitant cost of medical care wipes out his meager savings in a very short time.

Arrangements for the insurance and purchase of medical care are far from satisfactory. Many hospital insurance programs are on a "service" basis—that is, they assure that, in some instances, full payment of hospital bill, but we have not yet been able to assure full payment of medical and surgical care on a prepaid basis, with the exception of a few pilot demonstrations of prepaid group medical care plans.

Blue Shield Plans

Under nonprofit Blue Shield plans there have been attempts to provide service programs through the establishment of income ceilings—setting dollar amounts which meant that workers whose family incomes fell under those ceilings were assured that the participating doctors would

accept Blue Shield fees as full payment of the bill. Those income ceilings were too low, usually \$2,500, to have real meaning for the worker fully employed.

In the past year Blue Shield plans have raised the ceilings, accompanied by substantial increases in the scheduled fees to doctors, but many doctors are now refusing to participate or are charging additional amounts for services which were formerly considered to be covered by the surgical fee—for example, post-operative care.

It is becoming increasingly evident that workers are not receiving full value on their surgical insurance because of the additional fees being extracted from them for surgical operations above and over the payments provided through surgical insurance. In contract reopenings on the subject of health security, some locals have increased the surgical schedule in the hope that it would prove more adequate and possibly provide full payment of surgical costs when illness in the family strikes. It is now recommended that local unions should not negotiate increased surgical schedules in their health security programs. The reason for this recommendation is simple—increasing surgical schedules in order to eliminate additional charges to workers doesn't work.

Cash Indemnity Basis

Most insurance against the cost of surgical care is provided on a cash indemnity basis. The contract is between the insured and the insurance carrier—the doctor is not a party to the agreement and is therefore free to charge more than the scheduled amount. Even where the doctors have agreed in advance to accept the schedule of benefits as full payment for services rendered, the full-payment guaranty is extended on to workers earning less than a specified income ceiling which often is too low to offer real protection for most workers.

Experience has shown that doctors commonly charge more than the scheduled allowances provided through insurance. The Senate Committee on Labor issued a report on "Health Insurance Plans in the U. S." and cited a number of studies which showed that, on the average, insurance covers between 40 and 60 percent of the total surgical charges by doctors.

One of these studies conducted by a committee of the Actuarial Society of America analyzed 100,000 surgical claims and concluded that surgical

insurance covered, on the average, only 55 percent of doctors' charges. In a UAW study, it was found that the surgical schedule was most nearly adequate when it came to minor operations, but that for the more expensive operations—when protection is needed most—the doctors' charges exceeded the schedule allowance in more than 9 out of 10 cases.

The important point is that increasing the surgical insurance schedule does not solve the problem because the doctor, and sometimes the patient, feels that the insurance allowance is money already earmarked for the doctor—and that the doctor, therefore, is justified in charging additional fees. Thus the worker pays twice—once through premiums and again, out-of-pocket in a separate additional fee to the surgeon.

In one case, two surgical schedules in effect in one area were compared. It was found that although one schedule was one and one-half times as high as the other and paid \$26 more on the average than the lower schedule, the workers' out-of-pocket payments were reduced by only \$6.

The chief result of the higher schedule was to increase the amount paid the surgeons an average of \$20 for each operation. Even in situations where the surgical schedule was doubled, workers have soon found that they still had to pay about as much directly to the surgeon as before. In cases where doctors agreed informally to certain high fees as full payment schedules, the Union has found that a year or so later the informal agreements were being violated and the workers were again being overcharged.

Increasing surgical schedules under these circumstances represents nothing more than "built-in inflation" and is no substitute for a full-payment service program at reasonable cost.

Improving Other Benefits

More effective use can be made of money which would otherwise go to increasing surgical schedules by improving other health security benefits. Hospitalization should be improved where coverage is not up to the standard of full payment of semiprivate accommodations and all other hospital charges for 120 days. Weekly temporary disability benefits should be adjusted upward where they have been falling behind the increases in living costs.

Extreme caution should be exercised, however, in liberalizing in-hospital medical benefits or in

adopting home and office medical benefits, because the problem of the cost of inflation for these medical benefits is virtually the same as the problem of the cost of inflation for surgical care.

But an even greater fault is the incomplete care that our workers are receiving today. Almost nowhere can the worker prepay for a program of preventive care, where his own needs and those of his family can be treated on an ambulatory basis. Early diagnosis and preventive treatment programs would diminish the excessive and costly use of hospitals and surgery today. Also, no medical care program is complete without rehabilitative services. Very few plans provide safeguards to assure a high quality of care.

Only Protected While Employed

Another very serious deficiency of these plans is that the workers remain protected only while they remain employed. When a worker is laid off, retires, or otherwise is separated from a group, the protection that his family has under the program very soon expires.

Under commercial group insurance plans, there is generally no provision for conversion to individual health insurance plans. Under Blue Cross and Blue Shield plans, conversion is possible, but the benefits are usually greatly reduced, age and other restrictions imposed, and maternity benefits especially curtailed. Furthermore the premiums for individual coverage are often not only substantially increased, but they must also be paid three months in advance—a large chunk out of the pocket of a worker receiving \$20 weekly unemployment compensation benefits, or the average pension of approximately \$110 a month.

Executives Adopt Health Examination

The following quotes from the Wall Street Journal, June 6, 1952:

Over 400 corporations from Maine to Southern California have adopted executive health programs in one form or another during the last few years. About 30,000 of their executives are being put through the mill each year at no cost to the executives. The company picks up the tab.

Examinations are generally pretty comprehensive. For a typical one costing around \$100 an executive is put through a complete medical-history check and clinical examination, including blood-chemistry, serological, electrocardiographic, metabolism, dental, chest X-ray and kidney and liver studies. Throw in another \$30 to \$50 and he gets specialized X-ray work, such as studies of the

gastrointestinal tract. All this is exclusive of possible travel expenses to clinics which the company also pays.

It isn't any different from what an individual can obtain for himself by entering any one of the 70 or more clinics throughout the country, that specialize in this kind of work. What makes it unique, however, is the fact that the employer takes the initiative in urging an executive to look after his health and even makes the necessary clinical arrangements and gets the bill.

Most companies refer their executives to clinics and physicians approved by their medical directors. Some, like Goodyear Tire & Rubber Co. are set up to do almost the entire job in their own company-run hospitals.

Chrysler Corp. sends the men who run its business to the Mayo Clinic in Rochester, Minn., "to give them a change of scenery." So does Hotpoint, Inc., subsidiary of General Electric. General Motors has a list of 63 clinics, approved by its chief medical director. It has 4,000 men who are eligible each year for the examination, by far the largest of any company. Republic Steel Corp. has an arrangement with the Cleveland Clinic to do the job.

Firms Use Greenbrier Clinic

Chesapeake & Ohio Railway offers something different to 155 executives on its eligible list—a 3-day stay at the Greenbrier Clinic in White Sulphur Springs, W. Va., associated with the famous Greenbrier Hotel, which C. & O. owns. Half of each day is devoted to sports and other personal enjoyment and the other half to examinations.

Thirty-six leading companies, topped by U. S. Steel Corp., used the Greenbrier Clinic in 1951, dispatching several hundred key men for a once-over. The clinic has doubled the number of its clients each year since it was founded in 1949—an indication of the growth of executive health programs.

Over 90 percent of all eligible company officers take advantage of the opportunity.

We say, "Good health is good business—everybody's business."

The Southwest Health Record

There are many other facts we could present today about the health needs of the people of the Southwest—that Texas falls with the lowest third of the Nation with respect to infant death rate and number of people per physician. That facilities and health personnel are unevenly distributed throughout the area, leaving many persons with still less or no protection. Fifty-four point six of the population of Texas live in rural areas, as defined by the U. S. Bureau of Census, population with residence in open country or in communities of less than 2,500. In urban places with population up to 10,000 there are available only 1.3 beds per 1,000 people.

The following is a record of services available in Texas by comparison with other States:

General hospital beds per 1,000 population in 1946: Texas, 2.5; New York, 4.8; Minnesota, 4.5; Washington, 3.9. Days hospital care per capita, 1946: Texas, 0.64; New York, 1.42; Minnesota, 1.34; Washington, 1.11. Number of persons per physician, 1940: Texas, 930; New York, 496; Minnesota, 792; Washington, 790. Number of persons per dentist, 1940: Texas, 3,179; New York, 1,314; Minnesota, 1,344; Washington, 1,376. Percent of births in hospitals, 1946: Texas, 72.3; New York, 96.9; Minnesota, 95.2; Washington, 98.2. Infant deaths per 1,000 live births, 1946: Texas, 41.7; New York, 29.1; Minnesota, 28.6; Washington, 33.4. Maternal deaths per 1,000 live births, 1946: Texas, 1.6; New York, 1.2; Minnesota, 0.9; Washington, 1.1.

This record is somewhat disgraceful when compared to other States whose opportunities are no greater than is Texas. Sure the dates are past, but very little, if anything is being done to improve the situation in any way by our Texas government.

A very shameful and disgraceful example is the facilities for mental patients. Neither should we sell ourselves short on the growing need for caring for our juvenile delinquents. But I am here to represent workers and to explain the health needs of workers in this region. Basically, their needs are no different from those of workers in any other part of the country. The International Union, UAW-CIO, president, Walter P. Reuther, in a report to the membership a year ago stated:

Our achievements in this field are substantial and we have made a good beginning. We must, however, press forward both through collective bargaining and through legislation to completely remove the price tag from good health and to eliminate the economic hazards of sickness and accidents.

Doctors Needed

There is pressing need for aid to medical education to increase the number of doctors, nurses and other health personnel. We need more money for public health programs, expansion of hospital facilities, and medical schools. Medical schools turned out fewer graduates in 1949, than in 1905, although our population grew from 75 million to 150 million.

It should be noted that one-third of the American people live in families with incomes under \$2,000 a year. Half live in families with a total income of less than \$3,000 a year. Every effort to meet our health problem has been fought bitterly

by use of the old scare words, "Socialism" and "States' rights."

The American Medical Association has turned itself into a powerful political force devoted to upholding the conservative "States Rights" coalition in Congress at the expense of the people's health. The Department of Agriculture in 1947 spent \$30 million for research in the plant and animal diseases. The amount spent by the whole Government for research in the medical and allied sciences was only \$28 million.

The Birthright of Good Health

Good health is part of the birthright of Americans' high standards of public health, an adequate number of trained physicians and dentists and nurses should be expected as a matter of course in a rich and powerful nation such as ours. Improvements of the Nation's health today has been blocked by doctors in politics. Progress depends on votes in our legislature and our Congress.

The American Medical Association will not support or even tolerate support of the State and local public health services. Local health services are responsible for the safety of food and water supplies. They are police services against epidemics. They form the core of the agencies that might have to be greatly expanded in case of war or other mass disaster.

The last absurdity occurred on May 19, 1952, when a bill to increase social security payments by \$5 a month—out of money already on hand—was suddenly blocked by opposition of the American Medical Association. However, after considerable thought and much talk, not to mention the cost of the taxpayer, the absurdity was recognized and the bill was passed, but still with AMA opposition.

Disability and sickness, as well as unemployment and old age, are natural hazards of life. A representative government has a right and a duty to provide protection against health hazards.

The record will show that politics should be removed from our medical schools and our medical schools removed from the vicelike grip of politicians.

It is our fondest hope that a suitable prepaid health program can be worked out for all the people. Such a program should certainly not be run by politicians, for political gains. Therefore, we believe that such a program should be under the auspices of medical training schools. We

further realize that the leadership to undertake such a program lies within the scope of the medical profession. Because there has been no program through which workers could prepay for their comprehensive medical care, they have purchased their protection from voluntary plans.

We of labor have evidenced our determination and our willingness to cooperate in every way to achieve better health standards for our people as well as those outside of our organizations, and will continue to work for such a program. However, to the extent that labor is unable to accomplish its objective of comprehensive care through those agencies, it will turn to the Government for assurance of protection. May we emphasize the fact that "Good health is everybody's business."

Statement ¹ of

MR. JEROME POLLACK

Consultant, International Union, UAW-CIO

Social Security Department

Detroit, Michigan

We are grateful for the opportunity to appear before you to discuss the health problems of UAW-CIO members and their families, and to report to you on the experience of the International Union in trying to lift the economic barriers to good health.

Auto Workers' Campaign for Health Security

It was natural for unions to become concerned over the threat of unpredictable and often disastrous medical and hospital expenses. The UAW long ago realized the futility of attempting to meet this problem by "passing the hat" for unfortunate members and the inhumanity of permitting the afflicted to bear the burden alone. Prepaid hospital-medical care has become a key feature of collective bargaining. The responsibility of employers for health security has been established; under collective bargaining contracts employers are making substantial contributions toward health protection. Today, over a million employees and over two million dependents are covered by health programs negotiated by the UAW. Each month last year workers and their dependents received more than \$10 million in benefits. This year, the total will probably exceed \$150 million.

¹Delivered at the Regional Hearing at Detroit, Mich., September 23, 1952.

The UAW explored the kind of arrangements that could be made with doctors, hospitals and prepayment plans—both nonprofit and commercial. The Union had to choose between service plans which pay for specified services in full, and cash indemnity plans which advance a limited amount of money toward the hospital or medical bill. Cash indemnity plans are merely deductible insurance in reverse—they protect the insurance carrier, which has to pay no more than a limited amount; the worker is left with the rest of the bill which has no preestablished ceiling.

Cash indemnity plans, especially under commercial insurance, often observe restrictive underwriting practices. Generally, they do not cover infants in the first few weeks of life; some do not allow working wives to buy protection for dependent husbands. Administrative costs are often excessive—partly because of the large commissions paid to agents and brokers. Individual health policies abound in “fine print” restrictions; only half of the premiums are returned in benefits, and some companies follow the scandalous practice of canceling the insurance for people in failing health who are regarded as “bad risks.” We have found, therefore, that the service basis was the only acceptable way of purchasing health protection.

Hospital Care

Although the UAW's programs are still in their infancy, substantial progress has been made in lifting some of the barriers to health security. The greatest advance has been in prepaid hospital protection on a service basis. Today a majority of UAW families in Michigan are entitled to full payment of their hospital bills for as many as 120 days.

Every day more than a thousand UAW workers and family members are admitted to hospitals. Most of these patients remain in the hospital for about a week. Often their bills are very high. Every hour in each working day of the week a UAW patient begins a hospital stay costing \$1,000 or more. Most of the hospital bills are paid in full by the hospitalization plan negotiated by the Union. Last year actual payments for hospital care totalled \$50 million.

Unfortunately, a great many hospital benefits are still on a cash indemnity basis but, for the most part, it has been possible to secure satisfactory group arrangements for hospital protection,

at least while the employees are working and covered under the program.

Medical Care

The Union also wanted to provide comprehensive prepaid medical services of high quality for the workers and their families, but this proved to be impossible. Practically nowhere could the full range of necessary and insurable health services be secured on a prepayment basis. Under the limited surgical-medical insurance which prevails, cash-indemnity plans predominate. Only three to four percent of the five million persons insured for surgical-medical benefits in Michigan at the end of 1951, were entitled to service benefits for in-hospital medical and surgical care. Virtually all people covered under commercial plans and some 95 percent of those enrolled under Blue Shield were covered only by cash indemnity allowances.

In practice, many surgeons apparently take for granted the insurance money as already earmarked for them. Often, in final disregard of the insurance, they charge such additional amounts as they believe the patient will pay. Although the workers have already paid for insurance, either through payroll deductions or by employer payments in lieu of wages, the benefits are not given the same weight by the physician as the out-of-pocket payments by the worker. A comparison of the charges to people with and those without insurance shows that the relief afforded by surgical insurance is often negligible. Let us illustrate.

The UAW has tested the actual protection provided by surgical insurance. One group of 20,000 employees and dependents increased its surgical insurance to a \$200 maximum schedule. This plan paid \$100 for an appendectomy, \$30 for a tonsillectomy, \$125 for a double hernia, and so forth. Every surgical operation which occurred in a sample period was recorded. The average allowance paid by insurance was \$51.52. The surgeon's charges averaged \$80.13 requiring the employee to pay an additional \$28.61. In only one case out of 12 was the bill paid in full.

Another group tried a higher schedule of benefits—the fees prescribed under the Michigan Veterans' Administration schedule, which is accepted as full payment by physicians under the Veterans' Administration Home Care Program. Here the average insurance payment to doctors was \$77.08. However, the surgeons charged \$100.07 on the

average, leaving the employee with bills averaging \$22.99. Although, under this schedule, doctors received about \$26 more than in the first group, from the workers' standpoint the higher fee schedule brought about relief of only \$6.

Fuller Coverage Sought

Efforts to negotiate still higher indemnity schedules to doctors in the hope of securing full payment are futile. A year ago, Nash-Kelvinator workers at Grand Rapids received verbal assurance that their \$300 benefit schedule would mean full payment of surgical care; today, the physicians are no longer honoring this schedule as full payment.

Michigan Medical Service has taken a step in the direction of providing service surgical-medical care under its \$5,000 income ceiling contract. Full payment of surgical and in-hospital medical care is offered for single workers whose earnings are \$3,750 or family workers with \$5,000 or less. Inflationary pressures, unfortunately, make these income ceilings too low. Furthermore, this contract is expensive, which accounts for the small proportion of Michigan Medical Service members who have subscribed for it.

Even in the few instances where surgical and in-hospital medical care are paid in full, only a small fraction of the average family's medical bill is covered. According to many estimates, in-hospital medical and surgical care account for no more than 15 percent of the average family's medical expenditure. We are spending far too much effort and money on this slender segment of medical care; and far too little in meeting the vast areas now uncovered.

Prepaid surgical-medical insurance, on the whole, has chosen to cover risks which are more easily insured, rather than those which reflect the most urgent need for health services. The insurance industry and the voluntary nonprofit plans approach health insurance with a strong preference for infrequent, costly and clearly defined contingencies which cannot be controlled by the insured. This preference is dictated by administrative convenience—not from valid health consideration. Cash payments are made to take care of the ingrown toenail and the carbuncle, while heart disease and cancer are often excluded until the patient is brought to the hospital.

Restriction of coverage to hospitalized illness rules out almost all preventive and diagnostic care.

The plans are in the unsound position of paying for costly conditions, often too late, when the subscriber is hospitalized, but ignoring his needs when illness first shows itself or when it may be avoided entirely.

Protection During Layoff and Unemployment

Far more adequate provisions will have to be made to protect workers who are laid off, who retire, or are otherwise separated from employment. At present, the worker is protected only while he is actively at work. When he is laid off, coverage very soon expires—usually within 30 to 60 days. Under commercial group insurance plans there is generally no provision for conversion to individual health insurance policies. Under the Michigan Blue Cross and Blue Shield plans, the protection may be continued but the duration of hospital benefits drops from 120 to 30 days and for maternity cases a \$9 daily limit is imposed. Premiums for the continued coverage on an individual basis are not only substantially increased, but they must be paid three months in advance.

When employed, a typical auto worker in Michigan pays about \$4.40 a month—one half of the Blue Cross and Blue Shield premium for family protection. When his income is reduced to unemployment compensation levels, the charge is \$10.25 a month. He must pay a quarterly premium of \$30.75 in order to have continued protection at a curtailed level.

Special Plight of the Retired

The UAW is determined to do something about the plight of retired workers. Medical expenses are the single most important factor depleting their savings, and threatening their already reduced living standards. Their health insurance is generally discontinued. Individual protection is either not purchasable or prohibitive in cost. According to studies which the Union has made, 2 out of every 3 retired workers reported medical bills in the course of a year. The bills exceeded \$500 in 1 out of 6 cases; they ran above \$1,000 in 1 out of 24. One worker reported that he had spent more than \$2,500. When you consider that 4 out of 5 retired workers have a total income of less than \$2,000 a year, the seriousness of these largely uninsured and unpredictable costs is obvious.

Shortage of Medical Facilities and Manpower

The population of Michigan has been growing—since 1910 at a faster rate than the Nation as a whole. The State's economic position has improved; average per capita income has increased from \$649 in 1940 to \$1,734 in 1951. But the availability of doctors, dentists, nurses, and hospital beds has not kept pace with the State's population growth and its expanding economy.

Today, the people of Michigan have relatively fewer doctors, fewer dentists, fewer nurses, fewer acceptable general, mental and chronic hospital beds than the Nation as a whole. In Indiana the shortage of facilities and manpower is even greater than in most respects.

Doctors

In 1949, according to the American Medical Association, there was one physician for every 741 persons in the United States. In Michigan, the average doctor had to take care of 917 people and in Indiana, 926. Despite the fact that Michigan ranks thirteenth among the States in per capita income, it is twenty-third in availability of physicians. In outlying counties, medical manpower is spread even thinner. There is only one M. D. to every 1,321 people in Muskegon County to every 1,704 people in Isabella County, and to 1,911 in Dickinson County. On the whole, Michigan has the poorest doctor-to-patient ratio of any major industrial State in the Union. (Source: Bureau of Medical Economics Research, A. M. A., cited in *Our National Health Problem*, Research Council for Economic Security. Data on Michigan counties were obtained from the American Medical Directory, and the population figures from the 1950 Census.)

Dentists

In 1950, there was one dentist for every 1,777 people in the United States as a whole, but in Michigan only 1 for every 1,965 and in Indiana for every 2,008. (Source: Bureau of Research and Statistics, American Dental Association, "Population per Dentist based on 1950 Preliminary Census Figures.")

Hospital Beds

Michigan in 1951 had only 2.4 acceptable general hospital beds per 1,000 population—far below the average of 3.2 acceptable beds for the nation as a whole. (Source: *Public Health Reports*, March 1952, Vol. 67, No. 3—Hospital Beds in the United

States, pp. 312–315.) The State in fact, ranked forty-third in availability of acceptable general hospital beds. The deficit in hospital facilities is not made up by the large number of beds in substandard institutions which were rated unacceptable because of obsolescence, fire and health hazards and other deficiencies. New hospitals are being built and existing facilities expanded, but much more will have to be done to raise Michigan from its present backward position.

High Cost of Care

Michigan is one of the most highly priced areas in the country for the purchase of hospital and medical care. This has been brought about by the rising standard of living—which properly includes a higher standard of health services, by the great expansion of prepaid protection, and by the shortage of medical manpower and facilities.

According to the Survey of Current Business the median net income of doctors in civilian practice in Michigan in 1949 was the highest of any State.

In representative Detroit hospitals a semiprivate room, exclusive of any related expenses for services and medications, costs from \$13.25 to \$16 per day. Here are some of the charges as reported last week by the hospitals:

Grace Hospital.....	\$16.00
Harper Hospital.....	14.50
Ford Hospital.....	14.50
Alexander Blain Hospital.....	14.00
Deaconess Hospital.....	13.25–14.25
Delray General Hospital.....	13.50
East Side General Hospital.....	14.00–15.00
Mt. Carmel Mercy Hospital.....	15.00
Detroit Osteopathic Hospital.....	14.50

When the ancillary services are added to the bill, people rarely leave these hospitals without a daily cost exceeding \$20.

In 1951, hospitalized patients in Michigan were charged \$22.56, on the average, for each day of hospital care in non-profit, general and special short-term hospitals—\$6 more than the daily patient charge in the United States as a whole. Only in California was the charge for this type of hospital care higher than Michigan—\$24.89, but the over-all charge was lower. (Source: *Hospitals*, June 1952, Part II, pp. 16–17, 59.)

These costs are high even when the worker is employed, had prepaid protection, and the employer is defraying the cost in part or whole. For

the unemployed, these costs are obviously prohibitive.

We have raised a number of difficult and urgent problems. Some of them are matters that may be solved through community efforts, through collective bargaining and through prepayment programs. In others, Government—Federal, State, and local—will, as always, have to fill in the gaps.

We would like to call to your attention a pertinent observation concerning this hearing by W. K. Kelsey in his column "The Commentator" in last Thursday's Detroit News, citing President Truman's address before the American Hospital Association, Mr. Kelsey said:

"The President in his address said that the great progress made recently in the health of the Nation is due to cooperation between the Government and the people. There are those who condemn Government action in this field as socialism. It is more correct to say that it is the people who have acted through their Government to reinforce their own efforts. Certainly the great advances of the last few years in the construction of hospitals, in medical education, and in the production and distribution of aids to medicine, could not have been possible without Government participation—as President Truman made abundantly clear.

"The use of the Government by the people for their own purposes is not socialism, but democracy at its most efficient level."

Some of the steps that must be taken are:

1. To expand the scope of prepaid services to embrace the full range of necessary and insurable care, including preventive and diagnostic services.
2. To provide adequate hospital-medical protection and services for the retired, the unemployed, the disabled and the needy.
3. To improve and expand medical education, research and hospital construction.
4. To expand vastly the rehabilitation of the disabled as a matter of humanity and good business.

* * * * *

Dr. BABCOCK. Thank you, Mr. Pollack. Are there any questions?

Commissioner RUSSEL V. LEE. Mr. Pollack, do you think it is possible to get up such an insurance program with fees that people could pay and provide all those services?

Would your United Auto Workers be willing to pay the premiums necessary to give that complete coverage you want?

Mr. POLLACK. I might say, first, that the people have showed a remarkable willingness to pay for health security. They recognize its purpose and they recognize it is not just a minor fringe issue. However, the whole question of this and the answer to that is the most difficult to determine and will in time be determined as we move toward more comprehensive care.

I believe that it is true that there is an impulse, a feeling, that we have got to go toward a more comprehensive care program.

Commissioner LEE. You can get what you pay for if you are willing to pay the necessary premiums so that comprehensive care could be provided. If you want the comprehensive care, some agency must make up the difference between the premiums and the cost of service.

I question whether any labor groups would be willing to pay premiums of the size sufficient to provide as much care as you want.

Mr. POLLACK. I think it will be determined in time. We have a step-by-step problem. The first and most immediate step is the need for more comprehensive services. I would venture the belief that as more comprehensive services are approached the people will want to pay for them because they are obviously needed.

Statement¹ of

MR. PAUL BOWERS

President,

International Rubber Workers Union

Akron, Ohio

I am the Director of the Pension and Insurance Department of the United Rubber Cork Linoleum and Plastic Workers of America, CIO.

We have 180,000 members in our union, and with their families there are approximately 500,000 people affected by the programs we have negotiated in hospital and surgical fields.

Approximately 75 percent of our members and families are covered by the hospital program that provides seven, eight or nine dollars in daily hospital benefits with a maximum of \$150 surgical schedule.

¹ Delivered at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

When these people and members of their family are hospitalized, the insurance coverages which they have pay for only 50 to 60 percent of their bills.

We have a large number of cases where employees have had to go to the United Fund or, as other of you people better understand it, the Community Chest organization to seek out assistance to help pay the bills.

Total hospital bills running as high as \$2,000, \$3,000 or \$4,000 are all too frequent. Besides the impact of huge hospital and medical bills, a great many of our members were unable to afford the necessary medical care. They delay going to the doctor partly because of fear of expenses for medical service and partly from the fear of losing time from work and thus losing the only source of income from which they support their families.

Coverage of Health Insurance

In recent years we have run into the added problem of providing hospitalization and surgical insurance protection. Within the past few years thousands of our workers have been retired under recently negotiated pension programs. Only a small percentage of them are covered by hospitalization and surgical programs.

Most of them have to pay for these services out of the \$100 or so monthly pension income. We have found during the past few years that the hospital room rates in city after city have been skyrocketing. Insurance benefits practically are wiped out as far as the employee is concerned because of prevalent increases in hospital room rates. New and expensive modern drugs have tended to raise miscellaneous hospital fees to a point where these charges are frequently more than the charges for room and board in the hospital.

With our limited resources it is difficult for us to make adequate checks of claimed abuses by hospitals of the insurance programs in effect. We have sufficient information, however, to indicate that many hospitals are taking advantage of the insurance programs that we have negotiated and are billing patients rather high amounts for blood transfusions, drugs, laboratory fees and so forth.

On the other hand, we have found a number of doctors have been taking advantage of the surgical programs that have been negotiated.

Where benefits have been raised under these programs, the employee is no better off than formerly

as a number of the doctors proceed to raise their fees for the operation.

We have unlimited cases where doctors have charged two, three and four times the fee allowed by the insurance schedule, even where the schedule was rather generous and accepted as fair and adequate.

Some medical associations have opposed the introduction of service plan operation schedules with fixed payments. These programs have worked out well in other areas but are rejected by many medical associations.

* * * * *

Hospitals Lose Touch

In some cases we have found that hospitals have refused to render service until they knew what type of insurance program the patient had in effect. The head of one of the largest groups covered by hospitalization insurance put the situation this way.

Hospitals have continued to take advantage of the changes we have made in our benefit program for people who are hospitalized. The hospitals have lost the common touch they once had. They have lost the main purpose for which they were once organized.

Instead of being organizations of mercy dedicated to helping the people of the community, they have more and more turned their attention to becoming a profit-making institution.

Shortcomings in Health Insurance

Many of our insurance and hospitalization programs were written several years ago and because of the particular circumstances of the collective-bargaining agreements of which they are a part, it is impossible to have these programs reviewed and revised until 1955. We have sought in vain to get the major rubber companies with which we deal to voluntarily open up these insurance programs to fill the enormous gaps which have become apparent in them over the past few years.

These benefits do no more than cover in the average case approximately 60 percent of the bills employees incur.

Our union members in plant after plant have been forced to carry additional programs to help defray the hospital and surgical bills. This is not only inefficient, since it involves two programs

covering the same type of benefits, but is also extremely expensive since the second program must be carried on an individual basis and does not have the benefit of lower group premium rates.

One of the other shortcomings of the present insurance program is the lack of any provision whereby an employee can take advantage of preventive medicine or examination.

In many programs the employee has to be in the hospital to receive any examination whatsoever. As we have indicated previously the hospital situation is not adequate. The rooms are crowded and an employee who needs an examination oftentimes has to wait several weeks before he can fulfill an appointment.

This, in most cases, causes interference with the jobs and results in the loss of earnings. In view of the above comments it seems to us that there should be something in the way of legislation, or some other arrangement, whereby a man's whole life and entire plans for the future could not be completely wiped out and destroyed by the continued inadequacy of insurance coverages and unfair practices of some doctors and lack of regulations in hospitals.

* * * * *

(Prepared Statement Submitted by Mr. Bowers Follows:)

Shortage of Hospital Beds

Our union has found throughout the country that there has been a shortage of hospital beds, and that workers in one locality after another have had difficulty in securing the kind of accommodations they wanted, as well as frequent delays in gaining admittance to the hospital.

In the Akron area where over 150,000 rubber workers and their families reside, there is a definite shortage of hospital beds. It is our understanding that the American Medical Association considers 600 hospital beds per 100,000 to be the standard necessary for adequate care. This would mean that for Akron and vicinity there should be a total of approximately 1,800 beds.

According to the figures published by the American Medical Association Journal in May 1951, the Akron hospitals had a total of only 1,100 beds. Within the next few years there probably will be an additional three to four hundred beds added as a result of the building programs currently being carried on. Even if the maximum of four

hundreds beds are added there still will be a shortage for there will be, by 1954, only about 1,500 beds for Akron. The basic requirement, according to medical standards, should be closer to 1,800.

In Barberton, Ohio, which adjoins Akron, with a population of 75,000—there are only 78 beds in the 1 hospital in the town. A building program there will yield additional beds so the total will approximate 150 to 200.

Yet Barberton should have a minimum of 400 beds on the basis of the standard of 600 beds for each 100,000 population.

The shortage of hospital beds is illustrated by the report of some doctors who claim that when they call the hospital to arrange for a new patient to be entered they were told that there were no hospital beds available. However, the doctors were told that if they would discharge one of their patients at the hospital, the hospital would see to it that the bed vacated by the patient in the hospital would be given to the new patient whom the doctor was trying to hospitalize.

Rise in Hospital Room Rates

Another main problem our union has faced throughout the country is the continued rise in hospital room rates. We do not have the figures on exactly what changes have taken place in these rates in every one of the hundreds of locations where we have members of our union. A careful check of the room rates for the Akron hospitals shows a sharp increase in room rates in even a short period of the past 3 years. These sharply raised room rates have made obsolete the insurance schedules of payment for hospital rooms that have been in effect in the rubber and allied industries.

The table below shows the various changes that have taken place in the three types of hospital room service in Akron.

AKRON HOSPITAL ROOM RATES FROM APRIL 1949 TO
AUGUST 1952
CHILDREN'S HOSPITAL

	Ward	Semi-private	Private
April 1949-----	\$8. 00	\$9. 50	\$11.50 to \$13.00.
Nov. 1, 1949----	9. 00	10. 50	\$13.00 to \$14.00.
Nov. 10, 1950----	10. 50	12. 00	\$13.50 to \$17.00.
Mar. 9, 1951-----	12. 50	14. 00	\$17.50 to \$19.00.
August 1951-----	14. 00	15. 50	\$20.50.

AKRON HOSPITAL ROOM RATES FROM APRIL 1949 TO
AUGUST 1952—Continued

PEOPLE'S HOSPITAL

	Ward	Semi-private	Private
April 1949-----	\$7. 00	\$10. 00	\$11.00 to \$14.50.
Oct. 1, 1950-----	7. 75	10. 75	\$12.25 to \$15.20.
Nov. 12, 1950-----	8. 00	11. 00	\$13.00 to \$16.00.
Jan. 15, 1951-----	9. 00	12. 00	\$14. 00 to \$17.00.
Apr. 9, 1951-----	9. 50	12. 50	\$15.00 to \$18.00.
August 1951-----	12. 00	14. 50	\$19.00.
August 1952-----	12. 50	15. 50	\$18.00, \$19.00, \$20.00.

CITY HOSPITAL

<i>Surgical Building</i>			
April 1949-----	\$7. 50	\$10. 50	\$16.00.
Sept. 19, 1949----	8. 00	12. 00	\$16.00.
Oct. 3, 1950-----	9. 00	13. 00	\$17. 50.
Jan. 22, 1951-----	10. 50	14. 00	\$19.00.
August 1951-----	14. 00	16. 50	\$20.00.
<i>Maternity Building</i>			
April 1949-----	6. 25	8. 50	\$12.00.
Aug. 4, 1949-----	6. 75	9. 00	\$13.00.
Oct. 3, 1950-----	8. 00	10. 00	\$14.00.
Jan. 22, 1951-----	9. 00	11. 00	\$15.00.
August 1951-----	12. 00	13. 00	\$16.00.

ST. THOMAS HOSPITAL

April 1949-----	\$7. 25	\$9. 00	\$11.00.
May 15, 1949-----	7. 25	9. 00	\$12.00.
Dec. 1, 1949-----	7. 50	10. 00	\$13.00.
Dec. 28, 1950-----	9. 50	12. 00	\$15.50.
August 1951-----	12. 00	14. 50	\$17. 50.

As this table shows, in 1949 a semiprivate room in Akron hospitals cost between \$8.50 to \$10.50; today, the cheapest semiprivate room—other than maternity—is \$14.50, and goes as high as \$16.50. This increase of approximately 50 percent or more for hospital room rates has, as we said above, made all insurance programs in the Akron area that were written more than 2 years ago completely inadequate to do the job they were originally set up to do.

Other Hospital Confinement Costs

Besides the above changes in room rates, the rates for nursery care have skyrocketed in many parts

of the country. In Akron in 1948, there was a nursery care charge for the new born baby of \$1 a day. That fee was raised to \$3 a day the early part of 1951. At the end of 1951 the nursery care charge was raised still further to \$5 a day, and in 1952 it was raised to \$7 a day.

In addition to the actual charges made for room and board in the hospital the cost of each day's stay in the hospital has also risen sharply as a result of new increased charges for miscellaneous items such as drugs, X-rays, diagnostic tests, etc.

We now find that just about half the hospital bill goes for items other than the daily hospital room rate.

This means that the average rubber worker who is confined to a hospital in the Akron area receives an average daily charge of somewhere between \$22 and \$26 a day, depending upon the hospital in which he is confined—these figures are taken from actual records of thousands of hospital bills presented to members of one of the largest rubber companies in Akron.

Changes in Room Classification

Until just a few years ago a semiprivate room in an Akron hospital meant two beds in a room. However, within the past two or three years the classification of semiprivate has been changed, and today many rooms which formerly had two beds in them and were classified as semiprivate have four beds and are still classified as semiprivate.

Several years ago any room with more than two beds was classified as a ward. In a similar matter, rooms which were formerly classified as private rooms and had rates of \$20 per day, now have been changed to semiprivate rooms by merely adding an additional bed in the room. As a semiprivate room each bed had a charge of \$16 a day. Thus, a room which formerly produced a room-and-board rate of \$20 per day, now produces a room-and-board rate of \$32 per day.

Excessive Charges Asserted

Several years ago, we have been told, before the Red Cross furnished free blood to the hospitals, the hospitals charged \$6 to perform blood transfusions. Now, with Red Cross furnishing free blood to the hospitals we have seen many bills on which a high charge for blood transfusions is listed. We have one case in which a member was billed \$55 for a blood transfusion. We have another case where a man was billed \$44 for a blood

transfusion. In both these cases the blood was furnished free to the hospitals by the Red Cross.

We have had repeated cases where miscellaneous charges for drugs and laboratory fees have seemed to be excessive. For example, in one case there was a \$574 charge for drugs and dressings and a \$406 charge for laboratory fees. The administrators of the insurance program have asked the hospital for a breakdown of the laboratory fees, for they consider them to be far in excess of what the case demanded.

We have been told that when the miscellaneous hospital fee schedule has been increased the hospital bills have shown increased miscellaneous fee charges. One of the main groups in Akron covered by a hospitalization program has requested that all the hospitals, in making out the bills for any patient, itemize all drug and laboratory charges showing exactly how much is charged for specified units of penicillin, etc. Some of the hospitals have agreed to comply with this request, but other hospitals have objected on the grounds that such information is confidential and cannot be given.

The room rate schedules we have listed above in the table in some ways are deceiving. A check of hospital bills from the various hospitals vary little when the total daily charges are compared. For example, where the daily hospital room rate is somewhat lower in one hospital as compared to another hospital, the miscellaneous drug and other fee charges have been somewhat higher. It would almost seem as though the hospital was showing a low room rate in order to give the appearance that hospital care in that particular hospital was not being too expensive, but on the other hand making up for this somewhat lower room rate by higher charges for operating rooms, drugs, and so forth.

Another example for the type of excessive charges the hospitals have made is for various diagnostic tests. A patient under one of the hospitalization programs was confined to the hospital for a series of gastro-intestinal tests and was billed \$80. A special inquiry by the insurance people who called the hospital to check as to what the charges of this type of diagnostic treatment normally were revealed that these tests had a fixed rate of \$25.

The hospital knew that this insurance program paid for the full amount and as a result of this

type of overcharges this type of insurance coverage had to be discontinued.

A woman needed certain therapy treatments at the hospital. She had been given seven of these treatments and had paid \$35 for them. However, the hospital refused to give her any more treatments until the group insurance administrator had been called to verify whether or not the program under which the woman was covered would pay for continued therapy. Fortunately for the woman, the program provided that under certain circumstances, the maximum of \$25 for the first five therapy treatments (which the schedule called for) would not apply.

Abuses in Insurance Coverage

In some of the rubber shops in Akron employees have taken out, on an individual basis, Blue Cross hospitalization insurance in addition to the regular group insurance program in effect. The patient never receives any cash from the Blue Cross hospitalization insurance. His bill is merely reduced by the amount of the Blue Cross hospitalization benefits. Until recently, when an employee had both Blue Cross and the group insurance program at the plant where he was employed, his hospital bill would come to the plant with the amount of Blue Cross payment indicated on the bill and the group insurance program at the plant was asked to pay the difference.

Now, however, the hospitals in such cases have stopped indicating on the bill for the employee how much has been paid by Blue Cross, and merely sends the total bill to the group insurance claims adjuster at the plant.

Since there is nothing indicated on the bill that there will be payments against this bill by another insurance carrier, the adjuster has no recourse but to pay whatever the program at the plant will allow towards the hospital bill. Then several months later the insurance adjuster at the plant will get a refund of some money with a note that the Blue Cross paid a certain part of the bill and, therefore, the amount sent in by the adjuster was more than was necessary to cover the portion of the bill not paid for by Blue Cross.

The listing of room rates in any particular hospital does not necessarily mean that that room at such rates will be available for patients. For example, in the largest hospital in Akron a rate of \$12 is listed as a minimum rate. Yet only 3 percent of the rooms in that particular hospital

have a rate of \$12. More than half the rooms in that particular hospital have rates of over \$14. So, it is not only the room rate that is important in any particular hospital but the number of rooms available at each level of rate charges that is crucial.

Surgical Fees

Despite the fact that the Blue Shield program is run entirely by the doctors themselves, and the doctors draw up the schedules as to what is regarded as an adequate payment, the Summit County Medical Association has still refused a service plan schedule on surgical care. Medical associations in other parts of the country likewise are resisting for various reasons the adoption of such schedules. We have countless examples of cases where doctors have overcharged seriously on surgical operations.

Below we have listed just a few of the cases which are typical of the kind of overcharges that have come to our attention in reviewing bills presented to patients from our union on surgical services.

1. A man cut his finger on a fan belt in a rubber plant. He was charged \$500 for the surgery necessary. A check with other doctors revealed that a fair fee for the particular operation was about \$90. The patient was instructed to question the doctor about the charge, but the doctor refused to reduce his fee.

2. A woman was distressed by certain scars and pitmarks on her face and was hospitalized for certain sand papering treatment for these blemishes. Surgical charges made for treating the patient came to \$150. Other doctors questioned about the type and nature of the treatment stated that a fee for such care of about \$25 to \$50 would be adequate and fair.

3. Another individual had certain scars removed. He received a bill for surgical services of \$350. Most insurance plans provided for not more than approximately \$25 for similar surgical services.

4. One of the most generous of the surgical schedules in effect in the Akron area provides for the payment of \$100 in case of an appendectomy. Again, this schedule was set up with the cooperation of doctors who met to establish

what they felt were fair and adequate fees. Yet no more than 20 percent of the doctors charge only the \$100 called for by the schedule. About 50 percent of them charged somewhere in the neighborhood of \$125 to \$150. A significant proportion, about 15 to 25 percent, charged as high as \$200.

A check of charges on such other frequent operations, as tonsillectomy, hernias, and gall bladder operation, etc., reveal a similar pattern of only a few doctors charging what even the generous schedule provides, a large group charging anywhere from 30 to 50 percent more than the schedule provides and another group, about 25 percent of the doctors, charging just about double what the surgical schedule provides.

Anesthesia Charges

Similar problems are presented by charges made by other doctors who administer anesthesia. In some States, for example, Michigan, where a service plan is in effect on surgical operations and the administration of anesthesia a flat rate of \$10 is allowed for the first half hour and \$5 for each additional half hour. It is our understanding that the Industrial Commission in Ohio determines the payment in the case of the administration of anesthesia of \$15 for the first hour and \$5 for each half hour after that. In effect, this is actually the same payment allowance as that permitted by the Michigan Service plan. Yet, in the Akron area, for many simple operations, it is not unusual to receive bills for the administering of anesthesia as high as \$30, \$40, or \$50. One case where an operation cost \$35 the anesthetist charged \$50.

Based on the schedule allowed by the service plan and the Industrial Commission, this would be the equivalent of the patient in the operating room for these simple operations for as long as 4½ hours. Doctors in the Summit County area have been told about these excessive bills for anesthesia. There has been some minor improvement in the situation though much yet remains to be done. We have records of some cases where anesthesia fees have run as high as \$90 to \$120. When questioned as to why these fees are so exorbitantly high, no satisfactory answer has been secured.

Unpaid Portions of Bills

On hospitalization and surgical coverages, both for the individual employee and his dependents,

the coverages in the vast majority of cases for hospitalization and surgical insurance, both for the employee and the dependent, provide benefits which still leave major portions of bills for these services unpaid. In only one or two of our local unions in the whole country is there any kind of provision for medical care. In all other locations expenses incurred by the employee when not confined to the hospital must be borne by the individual employee himself with no assistance of any kind of insurance program.

* * * * *

Our union members in plant after plant have been forced to carry additional insurance programs to help defray the hospital and surgical bills they are faced with. This not only is inefficient since it involves two programs covering the same type of benefits but it is also extremely expensive since the second program must be carried on an individual basis and does not have the benefit of lower group premium rates.

The above gives some indication of the inadequacy of the group insurance programs in effect on an over-all basis. Below are some individual cases which point up the real problems where a serious illness or injury occurs:

Case Histories

1. A worker was saving sufficient funds to take care of a hospital bill to cover his wife's confinement. The mother gave birth to triplets, each of whom was premature, and it was necessary to keep the babies in the hospital after the mother left. The cost of keeping these premature babies was \$12 a day for each one of the babies, or \$36 a day for the three babies. No portion of the hospitalization program covered such a bill. Above what money he himself was able to pay towards the hospital bill, and that which the hospitalization paid for, there still remained a balance of \$876.57 to be paid. The United Fund—the Akron Community Chest—had to step in and pay the bill.

2. Another employee had a total hospital bill of \$1,819 of which his insurance covered only \$661, and the patient himself paid an additional \$160. About \$1,000 of this patient's bill had to be paid by the United Fund.

3. In another case an employee had a total hospital bill of \$3,358. His insurance paid only

\$605. Over \$2,700 is to be paid by the United Fund.

4. A woman confined to the hospital over and above the hospital bill had a doctor's bill of over \$500 which was not covered by insurance. Again the United Fund had to step in and pay the bill.

5. In another case a worker had a hospital bill of \$3,076 of which his insurance paid \$417, and he had \$520 which he could pay. Since his hospital bill amounted to slightly more than \$3,000 the United Fund had to pay slightly more than \$2,000 for this employee.

6. In another case a worker 63 years of age had his home paid for and had saved enough money which he had hoped to use during his retirement at age 65. His wife contracted cancer and he had to use every single penny of the savings to cover the medical expenses and he still had medical bills of over \$2,200 which he was unable to meet.

7. An employee confined to the hospital for a 96-day period received a total bill of \$3,170. Of this bill \$574 was for drugs and dressings and \$406 for laboratory fees. Of this amount his insurance program, and he had an extremely good program compared to the others in Akron, paid \$1,816. This left the individual with a bill of over \$1,300 for hospital care alone.

8. An employee confined to the hospital for 37 days had total bills of over \$2,900. Of this amount \$2,000 was for drugs. Fortunately for this individual, his insurance program covered about 90 percent of his bill.

9. A girl in an automobile accident had to be hospitalized for a period of 38 days. Her total hospital bill came to \$797. In addition, she had surgical bills of \$600. In this case the patient was fortunate to be covered by the best insurance program in town, and the full \$600 was allowed on the grounds of the special circumstances involved in the surgical care. The same patient, under almost any other of the programs in Akron, would have gotten only \$150 to \$200 for surgical care.

10. Another patient confined to the hospital has total bills of \$1,304. Her surgical bill came

to \$750. Again, in this case, the patient was fortunate to be covered by the same insurance program as the patient in case No. 9. She received \$525 toward the surgical expenses and \$893 toward the hospital expenses.

From these cases and they are typical of literally hundreds more in the Akron area, it can be seen that not only are hospital and surgical bills not adequately covered by the group insurance programs in effect, but workers have, in addition, medical bills which no type of insurance program covers. In the case of the employee about to retire, whose wife contracted cancer, there were medical bills in the thousands of dollars which exhausted every single penny of his savings and forced him into debt. In the case of the woman confined to the hospital, medical bills of over \$500 remained after she exhausted every cent she had.

Other Medical Expenses

For many workers the cost of medical care is prohibitive. Doctors have told us that patients frequently come to them much too late in many situations. They postpone coming when the first symptom or illness appears and only come when the condition has reached a more acute stage. At that time treatment becomes very expensive and frequently it is too late to help the patient. This is especially true for the wage earners in a family.

Not only are the workers worried about possible medical bills, but they are also deeply concerned about the loss of wages. Consequently, in many ways the wage earner takes poorer care of himself while seeing to it that his wife and children get better medical care and treatment in terms of sending them to the doctor more regularly and not postponing their visits.

For example, a patient came to the doctor complaining about a lump in his stomach. The doctor strongly advised him to have X-rays taken because of the danger of cancer in the stomach. When told such X-rays would cost at least \$25 and would require the patient taking off a full morning from work, the patient said he could not afford to do that at that particular time but would try to get to it as soon as possible.

Illnesses or injuries frequently are not taken care of properly because of the financial strain on the individual brought about by absence from work. A patient who was out of work had to

have a cast put on her leg because of an injury. Shortly thereafter the patient received a call to return to work. At the time the cast was supposed to be taken off her leg the patient called the doctor to ask if the cast could not stay on longer so she could go back to work. She was doing work where there was little occasion to be on her feet, but with the cast off her leg she would be unable to return to work until the leg was sufficiently strong to bear her weight, even for short periods of time. With the cast on her leg she could return to her job since the cast would take the strain off her leg during those periods when she was on it.

Coverage of Medical Bills

Heavy medical bills that are in no way covered by any group insurance program are a common occurrence. These medical bills are frequently so high that they impose a real hardship on the worker and his family. Heart patients and arthritic patients especially must meet heavy doctor bills because of treatments they have to get. These people are not bed patients and get no part of their bills paid under any kind of an insurance program. Such treatments can easily run into the hundreds and thousands of dollars. Even in the other types of situations bills can often be very high.

For example, a doctor cited a case where a patient had a ruptured appendix and shortly thereafter fractured her hip. Within less than a 2-year period the bills for medical care for this patient were more than \$2,000. The patient was over 80 years of age and the medical bills had to be assumed by her son who was not in a position to meet such unexpected high expenses.

There is virtually no preventive medical practice in the Akron area. There is no screening of patients to detect conditions which may later prove to be serious. Diagnostic examinations are quite expensive and to take them in the doctor's office means to take them with no chance of insurance coverage payment for any of the bill. When the patient is confined to the hospital for at least an 18-hour period, diagnostic examinations may then be given and payments will be made under the hospitalization program. However, this creates another problem in that persons who in a sense do not have to be hospitalized are occupying them in order to get a diagnostic examination which they feel is necessary.

Statement¹ of

JOHN DESPOL

Secretary-Treasurer

CIO State Council

Los Angeles, Calif.

We have had an experiment in Los Angeles with something which I understand we were the first to establish on the West Coast, although it had previously been established in the East: That is the experience of health insurance trust funds.

It may be well that this Commission ought to explore the possibility of whether or not we can square the circle between those who argue for prepaid public health insurance and those who argue that the status quo of voluntary health insurance plans is adequate and is growing and is meeting the needs.

Our local experience has been that both the employers and the unions involved in this particular health insurance trust fund want to feel that this at least gives a partial answer at the present time, but by no means a complete answer. What we are particularly impressed with is not the amount of medical care we are able to give, which is quite limited, but the fact that this is a form of administration that brings about a meeting of the minds of the industry people and people from labor.

I would like to call an analogy to your minds, that it isn't so many years ago that we solved a similar problem in the passage of the Labor Relations Act, which provided for a National Board, permitting in that particular case a union to petition that board for an election. If the union won the election, it became the bargaining agency, and the employer and the employees proceeded to do business, the business of settling grievances and of providing a form of psychiatric care, if I may be so bold as to use a technical term. They seem to think it has had in part that effect.

I see no reason why the same principle of growth and advantage and development of our present health situation could not be secured by applying this principle of health insurance trust funds, in the plural sense, thereby avoiding the disadvantages of the present system and also eliminating the opposition to national health insurance.

Federal Health Board Proposed

How would that operate? It simply means that we would, first, need Federal legislation to establish the machinery of a Federal Health Board. Second, that in addition to all of the other material which Congress should put into it—and that the Commission should perhaps recommend in its wisdom—that it would provide that the citizens of a county or a State or a city, depending upon the unit you want to utilize, may petition such a Board or its regional officers to establish health insurance trust funds. This in effect would be quasi private, thus meeting the argument of the insurance companies, and meeting the argument of those in the medical profession who are more vocal, and the more silent members, on keeping this on the present principle of voluntary health insurance.

At the same time it would provide and meet the argument of those of us, such as the CIO, who have argued for Federal health insurance, that it would also be quasi public. If the citizens of a State or a city or county, for example, were to vote to put this into effect, then it would change from voluntary to compulsory, and the people involved in the voting unit would be those who would be covered. So far as the trusteeship itself was concerned, it seems to me that is something that could be worked out between the medical profession and all of the other organizations who have expressed interest in this field.

Control in the Hands of the Doctor

A friend of mine, who is one of the leading doctors in the State and a former chairman of the State Medical Board, says it is his firm opinion—and he is in my mind a fine, advanced and liberal thinker on this problem—that the control should be in the hands of the doctors. Perhaps the question of doctor control or of layman control of trust fund boards is of secondary importance. In any event, I for one feel enough confidence in industry and labor, and perhaps public representation, that even though they were a minority their voice would be heard if any of the difficulties were to arise in respect to some of the accusations that have been made against some of the medical societies.

What this would mean is, that once established in a given area or given State, then those trustees would have to determine whether or not the fund would be in effect a public fund or a private fund—

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

private in the sense of purchasing insurance, if the insurance companies provide it, or, if you have Permanente paying for Permanente, or for any of the innumerable varieties or forms of health insurance.

Advantages

This would provide, if it provided nothing else, as I suggest, utilization of all of the varieties and methods and plans that we now have in existence. And, further, there is no reason that it could not permit unions and industry, particularly unions, to petition such a board and take a vote, so that health insurance trust funds could be set up by industries as well as by States or counties or cities. In this way we would perhaps lose some of the theoretical advantage of centralization of administration. On the other hand, partial to bigness, I am inclined to think there might be more efficiency in this approach because the size of the administrative unit would be smaller and therefore more manageable.

It also would mean that not everybody would take the initiative it wants in any State or in any union or in any county—if you break it down that far. It would mean that those who took the initiative would have the first to gain, which I think is the real advantage of prepaid health insurance. Those who were laggards would have the chance to see how this would work out in practice, and if it worked out well I think the initiative would come from all over the country and the rush would be on.

If the rush were on, we would find—and I am also willing to predict this one—that actually the forms and methods of putting into effect health insurance trust funds would be to a large extent by purchasing from insurance companies, if they would provide the complete coverage (which they do not now provide), or else partially from them and the balance from public prepaid health trust funds at the local unit or the State unit. Then we would find, I think, that all of the argument that has been going on in this country for the last decade or so is an argument of words and not an argument of facts as to what the needs are.

Needs Evident

The needs have been there and evident for some time, and this Commission is in one respect regathering material that has been gathered a good many times in my lifetime.

It is for that reason that I raise the question as to the important things. I would like to leave it to the trustees of each health insurance trust board to determine what amount would go into purchase of voluntary private insurance, insurance companies, or the utilization of Permanente in this State where it is available, or the question of establishing additional facilities. Part of the money, no doubt, should be earmarked in each unit, perhaps set up as mandatory in terms of the Federal legislation, for research for hospitals and schools.

I don't have the time to address myself to those formulas, but there is no reason why there could not be earmarked money in the process of administering a series of trust funds that are quasi private, so as to meet all the arguments of the medical profession and at the same time satisfy the needs.

Dr. SHEPARD. I believe that is a new idea to some of us. Would any of the Commissioners like to ask questions at this time?

Commissioner RUSSEL V. LEE. Your idea as to this program for health trust funds is a novel one. I don't think we have heard it before. Have you submitted a brief covering that in detail?

Mr. DESPOL. I have not for the reason that I have been preparing for a State convention, which we have just finished. I just didn't have the time between midnight last night and today to write it.

We would like to have the privilege of submitting a brief before your Commission makes its final report. We have had this under discussion for the past year, at least in the State of California, looking at it from the point of view that, if the Federal Congress fails to act, we can bring up the question of providing enabling legislation through our State Legislature. We are going to take the initiative, one way or another.

Commissioner LEE. We would appreciate your having it sent in to the Commission at Washington, if you will get it ready.

Commissioner LEE. I have a question. You are the treasurer of the group in Los Angeles, are you not?

Mr. DESPOL. I am Union Trustee of the Board of Trustees that administers the fund there.

Commissioner LEE. We are always faced with the necessity for making realistic solutions. We have a lot of aspirations that would require all the personnel, all the money in the country to achieve. How much money per month per employee or employer do you think would be available for a health plan?

Mr. DESPOL. Before I answer that question, let me answer one that you haven't asked and should. Where the union petitions, the union should have the right—which it already has—to see if the employer—the corporation—foots the entire bill. Insofar as the city and county boards, or State boards, are concerned, the trust funds that I mentioned would obviously have to be undertaken at the outset by some method of formally submitting it, or whatever formula came out of it.

As to how much it would cost, I think there would have to be more experience and testimony than I have, to answer that particular question. I would certainly say that whatever the amount may be, whatever the actual dollars turn out to be, and whatever the British experience would indicate, where you have this complete coverage—or if you took Senator Douglas's suggestion, where you didn't take care of the first \$100—whatever that amount may be, I make one very important point: From our experience with Permanente and with the Kaiser Steel Corp.—because it was the Kaiser Steel Corp. that made that thing possible, in cooperation with the union, in getting the fellows into it—whatever that cost may be, it will be less in the amount of money saved in the way of preventive medicine and keeping people healthy on the job and turning out more production. We have had test studies on this in our union involved there. And I think that at the Lockheed Aircraft Corp., with the cooperation of a doctor from Cal-Tech, they made a specific study on the question of the use of vitamins which indicated that the cost was more than made up by the difference in production between the two test departments that were identical in every other respect.

So when you talk about costs, I say you are not talking about increasing costs but you are talking about decreasing costs, if you put the system of preventive medicine into effect.

Commissioner LEE. You may be able to give me what I want if I ask the question in another way. You have 75,000 covered now. What is the average health benefit for them at the present time?

Mr. DESPOL. Those that are covered now, their medical needs are met between 45 and 20 percent. I doubt if there is any over 40 percent. There are very few that will meet even half of their medical needs.

Commissioner LEE. What is that costing now, that inadequate coverage?

Mr. DESPOL. Well, take the present trust funds, which happen to provide \$4,000 life insurance in addition to the health insurance. You would have to compute the cost of the two together, the \$4,000 life insurance plus two-thirds of my medical bill. I had a \$1,800 medical bill, which was covered by \$6 per month, paid entirely by the employer.

Wait a minute. Did I say two-thirds? One-half was paid by the \$6 of that medical bill that I was covered on. The reason why I said two-thirds is that originally the 1 percent that the employee pays in this State under sick leave disability insurance is also included in that thing, so my sick leave payment helped make up the two-thirds figure that I gave you. But when we include the dependents, in addition to the employee, then the percentage drops down substantially because of an existing fund of \$10.16, \$8 of which is paid by the employer and \$2.16 by the employee.

In other words, the employees pay for the health of the dependents, approximately, and the employer pays for the entire employee insurance. That would be substantially less than the figure I gave you for the employee. I doubt if it hits the 30 percent mark at the present time, although as the reserve builds up, the insurance reserve, we hope, will make equal benefits for the dependents as well as the employees.

At the present time we are operating on the principle that industry should pay for maintenance of human accidents, such as they already pay and have for a great many years for the maintenance of machinery when it comes to breakdowns.

Commissioner DEAN A. CLARK. I would like to ask one question, which perhaps isn't pertinent here.

How satisfied is the CIO in California with the treatment accorded by general practioners as compared to specialist, from the standpoint of ability?

Mr. DESPOL. I don't think anyone can give you an honest answer to that question: It is a spotty situation. You hear those who are extremely well satisfied and who feel that they have very adequate attention from their particular practioners, or, for that matter, from their specialists. On the other hand, the union, by its very nature, will hear complaints, and we hear more complaints than we hear from those who are satisfied. So if I were to tell you that the majority of what we hear is dissatisfaction, I would like to underscore the fact

that I am trying to be honest in this matter by pointing out that it is normal for us to hear from people who are complaining. We get a tremendous number of complaints—when the fees go up and insurance goes up, and that sort of thing.

I have no particular solution to that problem at the moment. How widespread that kind of complaint is—it would take a substantial amount of money to make a survey to get some accurate information. My feeling is that the situation is quite spotty, and I can't generalize.

* * * * *

(Attached statement of Mr. John A. Despol, submitted to the President's Commission on the Health Needs of the Nation, follows.)

This summary will be submitted in the following sections:

A. Observations on the present situation.

B. A suggested approach to the Commission on Questions Two and Three, namely "What can be done to meet those needs" and "How can Medical Care be best provided".

C. A history of the Union-Management Trust Fund established by the United Steelworkers Union in Los Angeles.

Observations:

1. If modern medicine were made available to all, a great deal of the waste of human life and the loss of production caused by ill health would be prevented.

2. The financial barrier and the uneven development of medical facilities are two of the most important obstacles to all maximum medical programs of American families. In connection with this, the distribution of income in the United States in itself indicates the nature of the financial barrier to adequate medical care for the vast majority of the population.

3. Hardly a beginning has been made to meet the needs of catastrophic illness.

4. (a) All the voluntary health plans have shortcomings. I am sure these shortcomings have been adequately outlined in other testimonies submitted to this Commission.

(b) The outstanding fact is that half of the population which has limited voluntary prepayment insurance protection, is nevertheless in need of substantial increase in the financial protection afforded, if all reasonable percentage of their medical bills is to be defrayed under the

insurance principle. Only 8 percent of the Nation's total medical bills is defrayed by all plans combined. If only the private medical expenses of the population were considered, then the percentage paid by the entire existing medical care programs amounts to nearly 12 percent of the Nation's total private medical bills.

5. Thus it should be clear to the Commission from all the testimonies submitted to it, that the voluntary plans, while increasing in coverage and in meeting the needs of the population, still leave much to be desired. Even if everybody had coverage under the existing plans, only something like 30 percent to 40 percent of the potential insurable expenditures of American families would be covered. Certainly there can be no serious disagreement with the objective of raising these standards so that somewhere between 80 percent and 90 percent of the potential insurable expenditures can be covered. I believe that these developments of health insurance could perhaps be best achieved through the instrumentality of Health Insurance Trust Funds discussed below.

6. There is no reason why the insurance principle of medical care plans should not go beyond the existing limitations of only hospital and surgical benefits during acute illness and to include a much more comprehensive coverage.

7. There is need to adopt an approach which will tend to decrease the amount of the dollar which goes into excessive administrative costs, brokerage commissions, abuses of the surgical margins now existing, etc.

8. Finally, there is no substantial reason to prevent the application of the health insurance principle to the public for improving the quality of Medical Care and encouraging the utilization of preventative medicine.

Health Insurance Trust Funds Approach

The answers to the questions "What can be done to meet those needs" and "How can Medical Care be best provided", may be found either in the National Health Insurance type program discussed by Anthony Ramuglia in the testimony preceding mine, or else in Health Insurance Trust Fund approach.

The Health Insurance Trust Fund approach provides the best aspects of both the existing voluntary health insurance program and the merits of so-called compulsory health insurance.

What is needed is Federal legislation which in effect would be legislation encouraging quasi private, quasi public Health Insurance Trust Funds. The enabling legislation could provide that the Trustees of Trust Funds established by Union-Management Labor Agreements should consist of trustees representing labor, trustees representing management and trustees representing either the public or the medical profession. Similar division of representatives could be worked out with Trust Funds established for a given city or county area by citizens of the governmental unit.

The Trust Agreements should provide:

1. For the method and amount of financing.
2. For the earmarking of part of the Fund for utilization for the increasing enrollments of schools of medicine, dentistry, nursing, public health and sanitary engineering; and for providing schools and maintenance funds to outstanding students in the field.
3. For the earmarking of funds for the establishing of additional medical research institutes, clinics, etc.
4. For the earmarking of funds for the construction of hospitals, health centers, clinics, etc.
5. That the trustees may purchase any and all available types of insurance including the service types and catastrophic insurance.
6. That where outside service may not be bought, the trust fund may act as a self-insurance if necessary to secure the maximum utilization of the money available in the Trust Funds and to achieve the 80 percent or 90 percent coverage of the medical bills of the families covered by the particular Trust Fund.
7. For the preservation of the private relationship between patients and physicians including a guarantee that both parties have full freedom of choice.

This Health Insurance Trust Fund would be quasi private, quasi public in that the enabling legislation would encourage the establishment of the Trust Fund by the citizens in a given city or county and by Agreements negotiated between Union and Management. The Trust Funds would be quasi private in that the Trustees in administering the Trust Fund would be under no direct governmental control, but would in fact run similar to existing Trust Funds now in operation.

(In this connection, attached as Appendix A is the description of the initial growth and administration of the Union-Management Insurance Trust Fund established in 1947 in Los Angeles, written by Miss Marge Lindley, who is an employee of the Trust Fund selected by the Management Trustees.)

A rough analogy of the kind of enabling legislation needed is the experience of the development of collective bargaining under the National Labor Relations Act. The National Labor Relations Act encouraged the establishment and the institution of collective bargaining by providing a method for both the Union and the Management to resolve the question of whether or not a collective bargaining instrument should be set up. Namely, the Union petitions the National Labor Board for an election. In practically all instances where the employees vote for the establishment of collective bargaining, the Unions and the Managements engaged in negotiations to secure a Labor-Management Agreement between them.

In this same sense a national or regulated Health Insurance Board could be utilized for the establishment of Health Insurance Trust Funds upon petitions by Unions and Managements. Secondly, for those citizens now covered by Labor-Management Agreements, a percentage of such citizens in a given city or county could petition for the establishment of a city or county Health Insurance Trust Fund. If the majority of volunteers vote for it, then the Trust Fund should be in effect for the citizens in that particular area. In other words, it should take local and volunteer initiative on the part of the citizens or else on the part of a given Union and a given Management. However, once established, the Trust Fund would be effective for all those coming within the Health Insurance Unit.

In developing a workable and democratic Health Program of this type, the country would not then be confronted with such a rapid expansion of the insurance principle as to increase the existing crises of a shortage of doctors, nurses, hospital facilities, etc., unduly. It would make for a more orderly growth and at the same time provide for a quasiprivate, quasipublic financing for meeting facilities now in short supply.

Organized Labor in the United States has rejected the idea of State controlled medicine. The theory that Government should directly hire doctors or other professionals, or that Government

should regulate unduly the professional practice of medicine or interfere with set rules for the private relationship between patients and their doctors, is a policy objectionable to Organized Labor. Thus we are attempting to expand all of the Health Programs that provide constructive alternatives to either the theorists of socialized medicine or to the politicians who cry that all that *can* be done in the field *has* been done.

Conclusion

We have attempted to outline a new approach that will square the circle between the advocates of compulsory Health Insurance and voluntary Health Insurance. If the Commission thinks well enough of this approach, we will be glad to spell out in considerably more detail the structure of a series of Health Insurance Trust Funds and the essential elements of enabling legislation to encourage the growth of same.

Submitted by:

JOHN A. DESPOL,
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APPENDIX A

When the Union Management Insurance Trust was formed in 1947, there was little experience data on which to model the plan.

There was no choice but to proceed by trial and error. Discussion and consultation. Experimentation. A principle adopted, only to be discarded later as impractical. Thus, the hilly history of the project is being made. But, through it all, runs a central theme—the genuine desire of both labor and management to make the plan work.

Basically sound, the answer of unions and management to the current demand for socialized medicine, this idea of interplant group insurance, administered jointly by unions and management, slowly is gaining ground in Los Angeles.

Proposed by CIO Steelworkers Local 2018, the group originally had 380 members, employed in two plants in the Vernon area.

Under the plan of insurance adopted, employees who had attained seniority (90 days of continuous employment) and who had worked 115 hours in the preceding month, were eligible for insurance. The companies agreed to pay the total premium—\$6 per month—for each such employee.

This \$6 more than covered the cost of insurance, so a reserve gradually was built up to pay the cost of administration, and to carry those qualified employees for a period of 2 months. A 2-month bridge originally was provided from the reserve for lay-offs, but this later was discontinued.

Other companies became interested in the plan and, by the end of 1951, 8 member companies with a total of 1,100 employees and 660 dependents, were participating in the Trust.

Gradually it is becoming easier to interest prospective new members, because of experience gained and the record of increasing benefits provided at competitive costs.

Benefits and costs by years from 1947 to the present, are tabulated on the next page.

The steady growth of the Insurance Trust, and its sound financial position, reflecting an excellent claim loss record and minimum administration costs, is shown by this tabulation:

	1947	1948	1949	1950	1951	1952
Number of Companies..	3	4	5	7	8	11
Number of Employees..	380	499	663	675	1,078	1,300
Number of Dependents..					660	850
Dividends Received..	\$11,937	\$15,225		\$19,954	\$40,447	

The Trust is managed by a Board of Trustees, composed of representatives of the union and member companies, the vote of the management trustees being equal to that of the union trustee. While provision was made at the beginning for an impartial trustee to act as arbitrator in any dispute, it is a tribute to union and management trustees alike, and to their willingness to give and take in their sincere effort to arrive at *what's* right and not *who's* right, that not once in the 6 years of operation has the impartial trustee had a decision to make!

Claims for benefits are sent through the personnel managers of member plants to the office of the union for investigation and payment. One union employee devotes half time to processing and payment of claims for union members, as well as other administrative work for the Trust, and one management employee spends about 10 hours a week on administrative work and processing and paying claims of nonunion members. The cost of administration was limited at the start to 5 percent of company contributions but, in the 6 years of operation, it has averaged only 2.4 percent.

Employees	1947	1948	1949	1950	1951	1952
	Cost \$5.39	Cost \$5.39	Cost \$5.39	Cost \$6.25	Cost \$6.25	Cost \$6.78
	<i>Benefits</i>	<i>Benefits</i>	<i>Benefits</i>	<i>Benefits</i>	<i>Benefits</i>	<i>Benefits</i>
Life.....	\$2,500	\$2,500	\$2,500	\$4,000	\$4,000	\$4,000.
A D & D.....	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500.
Hospital.....	\$8 (31 d)	\$8 (31 d)	\$8 (31 d)	\$11 (31 d)	\$11 (31 d)	\$14 (31 d).
Surgical.....	\$225	\$225	\$225	\$300	\$300	\$300.
Spec. Charges (inc. Ambulance).	\$80	\$80	\$80	\$220	\$220	\$280.
Medical.....				50 calls	50 calls	50 calls.
Diag. X-Ray.....				\$50	\$50	\$50.
U. C. D.....				\$40 wk. max (1.2%).	\$40 wk. max (1%).	\$40 wk. max (1%).
Polio.....						\$5,000.
Dependents				Cost \$4.16	Cost \$3.88	Cost \$5.27
				<i>Benefits</i>	<i>Benefits</i>	<i>Benefits</i>
Hospital.....				\$8 (31 d)	\$8 (31 d)	\$10 (31 d).
Surgical.....				\$225	\$225	\$300.
Spec. Charges (inc. Ambulance).				\$80	\$80	\$200.
Maternity.....				\$100	\$100	\$100.
Polio.....						\$5,000.

Among the problems involved was a fair determination of whether increased benefits should be provided for the advantage of present employees, or whether benefits should be continued to form a bridge for a period of 1 or 2 months for employees who were laid off. For some time, premiums were paid from the reserve for a 2-month period for layoffs, but this was discontinued when it was determined that it did not justify the drain on the reserve. At the present time, insurance is terminated at the end of the month in which an employee leaves his employment.

Another problem encountered had to do with payment of premiums for cases of nonindustrial injury or illness. At the present time, no payment is made beyond that for which the company is obligated. Current discussion, however, has brought out the fact that almost 90 percent of such cases return to work in a 60-day period, so it is probable that action will be taken to provide for premium payments from the reserve for at least 1 month for each such employee.

In all discussions, the interest of insured employees is paramount to every consideration except sound administration of the Trust Fund.

Numerous advantages have been gained. Employees have a sound plan of insurance for themselves and their dependents, administered fairly and understandingly. This has resulted in better morale and, consequently, in better work. Employees understand that the union and management are continually trying to refine and improve the program, and this can only result in better employee relations for management and better member relations for the Union.

Employees may consult a doctor of their own choosing, go to the hospital of their choice—in each instance receiving individual rather than group care—and, except in the most unusual cases, the insurance benefits pay most of the costs.

It is unthinkable that these 1,300 men and their 850 dependents would trade their insurance plan for socialized medicine. On the contrary, they form a convinced and convincing nucleus against all such proposals. On the other hand enabling legislation which encourages the growth of the "Trust Fund" plan approach, properly drafted and equitably administered, may become the meeting ground on which the majority of interested Americans can agree.

Statement¹ of

FRANZ E. DANIEL

State Director

North Carolina CIO

Raleigh, North Carolina

In the years since the formation of the CIO, we have seen the economy develop and expand, as free American enterprise has found new and larger markets—markets that have been created because the wages paid working men and women have risen until they could begin to have some of the creature comforts, above and beyond the bare necessities of living.

We feel that CIO's chief contribution to the welfare of the Nation, along with other trade-unions, has been the improvement of the health of all our people as they could afford more and better food and a better balanced diet.

Meat and milk consumption per capita has risen to staggering new heights. The same is true of fresh fruits and vegetables. And the health, vigor, physical fitness, stature and well-being of all Americans has reflected their improved diet—a diet that has been made possible by the CIO and other legitimate labor organizations whose members have helped raise the living standards of our entire country.

Dark Cloud in Bright Picture

But there is a dark cloud in this bright picture. Despite the economic gains organized labor has made in the past fifteen years, the facts show that we still have a long way to go when it comes to paying for hospital and medical care.

The average weekly industrial wage in North Carolina is \$46.50 as of February, 1952—and in yarn and thread mills, the predominant industry in this State, the average, according to March 1952, BLS figures, is \$42.95.

The point of that information is just this: The Bureau of Labor Statistics city worker's family budget for four people—which is no luxury budget by anybody's standards—requires at present prices a minimum of \$80 a week.

What does that mean in terms of expenditures for health?

On that budgetary standard, here is what is allowed for medical expenses:

One doctor's visit to the house per person per year.

Three visits to the doctor's office per year for each member of the family.

One tooth filled per person each year.

It takes 8 years to save up enough for a tonsillectomy.

That, gentlemen, is the standard possible when you earn \$2 an hour. But, in North Carolina, if you work in the wood industry, even in an organized plant, you average 97 cents an hour. And in textiles the figure is \$1.13.

At that wage, only two people in the family of four can afford to get sick in a year—the other two just have to die—and there is not even enough money to bury them.

Now, by and large, CIO members have a little better protection against the hazards of illness than most working people. Many of the textile workers in North Carolina, for instance, who work under CIO contracts do have both hospitalization and medical care insurance. Some 88.3 percent of North Carolina textile workers have some form of hospitalization insurance, and some 50.5 percent of them have additional coverage for other medical care.

But what do these plans amount to?

Health Plan Benefits

An average schedule of benefits is \$6–\$8 toward a hospital room, \$150 surgical fees, \$50–\$100 for incidentals and \$1,500 life insurance coverage. The plans generally pay about 35 percent–40 percent of medical expenses.

Those benefits cover only the worker, not his dependents.

Almost every plan requires that employees pay part or all of the cost of this insurance.

And, finally, these benefits do not begin to cover the cost of medical expense for the average worker's family. In North Carolina, a worker's family has only one answer to this problem: the only medical expenses incurred are for emergencies.

With this lack of preventive medical care, is it any wonder that so often a working family is bankrupted by the disastrous expense of critical illness?

Doctor Bills

A crying need, aside from a plan to provide for preventive medicine to avoid serious illness, is for some way to pay for the costs of chronic illness. Diabetes, for instance, when it strikes in the fam-

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

ily of a worker, means a constant drain on the pocketbook, not only for life-giving insulin, but for regular fees to the doctor for checkups and examinations and for laboratory fees.

With doctors' fees in North Carolina depending solely on "what the traffic will bear," and ranging from \$3 to \$10 for a visit, this kind of recurring expense is crippling.

Obviously in North Carolina there are more than enough patients to keep the doctors busy. The average private physician in North Carolina earns a net of \$11,765 a year and has all the practice he can handle. This State's four-plus million people spend \$10.33 a year on a per capita basis for the critical doctors' services they must have or die.

Surely, then, there is a way, with over forty millions of dollars going to doctors each year in North Carolina, to care adequately for the needs of the people.

The overall problems in North Carolina are these:

Major Problems

First, the major hospitals are concentrated in relatively few urban centers, Charlotte and Durham being the principal places where the critically ill can get proper specialized attention. The new medical facility opening at Chapel Hill will not relieve the problem geographically, since a worker in a sawmill in eastern Carolina still must travel 150 miles or more at his own expense—which is not covered by insurance, if he is lucky enough to have it—just to get to a medical center that can cure him.

Here is a statistical summary: Despite the fact that North Carolinians rank twenty-second in the Nation in the amount of income spent for physicians' services, they rank forty-fifth in the Nation in the number of physicians in proportion to population, with only 80 doctors to take care of each 100,000 people.

That, of course, is an average figure. It includes whole communities where not a single doctor is available and where doctors demand their fees in advance before they will consent even to see a patient.

The plain and simple fact, gentlemen, is just this: Working people in North Carolina, as in the Nation, cannot afford the burden of medical expenses within the wage scale they are paid.

The further fact is that, failing to get proper care, the health of the people of this State is substandard.

The dramatic proof of this was the rejection during wartime of over half the young men called by Selective Service in North Carolina. More than 40 percent of the whites and more than 60 percent of the Negroes were rejected for bad teeth, bad eyes, bad feet, and a variety of other physical defects.

And, inevitably, the result is either death or bankruptcy, and, even worse, a lowered standard of public health with all its penalties in terms of lowered human efficiency and heightened human misery.

Health Insurance Coverage

We in the CIO strive constantly to further the goal of adequate health insurance so that medical expenses can be planned for and so that proper care may be provided. We fight on the legislative front for laws providing such insurance, and we fight on the economic front to gain some measure of medical insurance for our members through collective bargaining.

But even if every CIO member in North Carolina had complete medical protection, that would still be only 50,000 out of over 4,000,000 people. And the cost of our insurance premium would be prohibitive because of the poor health of the rest of the people in the State.

We in the CIO know that the health and welfare of any individual is dependent on the health and welfare of all.

Few of these defects were acute. They were all the result of years and years of inadequate medical care.

Sickness—Cost and Payment

The question we in the CIO are concerned with is this: How long must the State waste its most vital resource—its people—through the attrition of chronically poor health?

On any given day in the State of North Carolina, over 200,000 people are laid up by sickness or injury. With industrial workers who are covered by State compensation, the tragedy is somewhat alleviated.

In North Carolina, workmen's compensation pays a maximum weekly benefit of \$30 for 350 weeks. But there is a joker in the law—the maximum total payment cannot exceed \$8,000 instead

of the \$10,500 that \$30 times 350 weeks presumably allocates.

And worst of all, under the North Carolina law, there is no provision for medical care nor for hospital expenses.

So in this most fortunate of southern States a working man faces the specter of financial tragedy as the result of industrial accident or disease.

On every count, the answer comes to the same thing. In the State of North Carolina, the most prosperous in the South, medical care and hospitalization are prohibitively expensive.

The situation in North Carolina is getting worse, not better. New industries are coming to the State and old industries are expanding. In Winston-Salem, Greensboro, and Burlington, to name just one instance, Western Electric is undergoing tremendous plant expansion calling for employment of thousands of new workers. Near Raleigh and Asheville new arms and electrical equipment factories are under construction. New textile mills are moving to the State.

To Live in Health and Happiness

In the first 7 months of 1952 alone, \$175,808,000 worth of new industrial construction contracts were awarded in this State with an additional \$25,790,000 slated to be let in July.

North Carolina is growing and prospering, but its people are suffering and dying for lack of proper medical care. And the burden on existing facilities, which are already overtaxed, is increasing almost daily.

On every hand the needs cry out to be met. The people's health is not a matter of private concern for some paternalistic industrialist to offer or withdraw, according to whim.

In North Carolina, this problem of the public welfare has not begun to be solved. A planned program is the answer. Insurance to prepay the cost of medicines and hospitals and doctors' fees is the American answer to the problem.

We in North Carolina are literally dying and our children are growing up warped and twisted and feeble for lack of an answer.

And we are the fortunate ones in the South—we are well-off compared to our brothers and sisters in neighboring states.

In the name of humanity, let us reject the wicked efforts of those who cry "socialism" in an effort to

maintain their iron control over the profession of medicine.

Let us abolish the horror of people who have not enough money to get well on and too much money to die on.

Let us find a way for people to live in health and happiness.

Statement¹ of

C. A. FINK

President

North Carolina Federation of Labor

Raleigh, North Carolina

Labor is vitally interested in the health of all of our people. We have a real concern for improving the health of the groups you have mentioned—the rural population, the Negro population and the tenant farmer population. Many of our future workers in industries will come from these groups.

Apparently the present health needs of these groups are due to:

1. The low educational level.
2. The low income and inadequate hospital and medical care plans to meet their needs.
3. Poor housing and sanitation.
4. Lack of medical, dental, and nursing personnel.
5. Lack of available hospitals.

If we are to help these groups improve their health status, we must work in many fields. Certainly we need more trained people—physicians, dentists, nurses, health educators and other health specialists. Furthermore, some plan must be worked out so that the health workers will be placed in our rural areas where the need is greatest.

Hospitals—with out-patient services—must be established in these areas. Well-staffed health departments, with a broad program of education and preventive medicine must be extended. Some form of health insurance, such as has been worked out by the North Carolina Medical Society, must be developed.

All of these suggestions will require local planning by representation of all groups concerned.

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

In the southern region we need financial and consultant service to help us solve the health problems peculiar to our own region.

National Health Program

The hazard of disabling sickness and death still confronts the great mass of American wage earners who are lacking adequate means to meet it. For more than two decades our Federation has pioneered in furthering studies of the costs of medical care and in searching for means to bring the medical service—for prevention as well as remedy—within the financial reach of every American family. Since 1944 the American Federation of Labor has been committed to a comprehensive national health program. Since 1948 we have sought the enactment of a basic seven-point program of federal aid to help provide the minimum safeguards to the Nation's health and welfare.

Progress toward our seven-point goal has been slow and difficult. As we reported a year ago, part 3 of our seven-point program was put into effect in October 1949, providing additional funds for grants to the States for the construction of hospitals and health centers under the Hospital Survey and Construction Act. We are glad to report that two other parts of our broad program have been enacted during the past year and are now operating for the Nation's benefit.

In August 1950, part 2 of our program was realized, when Public Law 692 was placed on the statute books, providing for Federal aid to medical research. Funds are authorized under this law to push a broad research program against common disabling and killing diseases. These include cerebral palsy, epilepsy, arthritis, rheumatism, multiple sclerosis, and blindness, in addition to other programs against cancer, heart disease, mental illness, and dental diseases.

Last year alone, more than 1,000,000 Americans fell victim to these common foes. By advancing medical research against these afflictions, we reduce this toll of needless suffering and death. In this ever-continuing fight against sickness, disability and chronic disease, Federal aid supplements and stimulates local and State funds, and voluntary contributions. Funds provided by the Eighty-first Congress are expanding research in miracle drugs like cortisone, ACTH and related compounds. These have already brought immedi-

ate hope to millions who suffer from rheumatic diseases.

Measures to Preserve Health

When expanded Federal research programs were first proposed, the usual bogeymen of bureaucratic control, waste, inefficiency, and "opening wedge to socialized medicine" were conjured up. Events have since conclusively dispelled these fears.

Today the Federal Government is the largest single contributor to medical research. In 1950, the Public Health Service made more than 1,500 grants toward this end. Yet, medical schools, hospitals, and universities throughout the Nation have received grants and employed these funds without interference or attempted control by Federal officials.

Since today false cries of "economy" resound in the midst of prolific spending, it is important to point out the total amount of Federal money spent for all medical research.

Through our concerted efforts in the past we have made substantial gains toward a comprehensive national health program, as a part of Social Security system, for the benefit of all American families. Three of the seven parts of our program are now public law. The daily challenge of communism, at home and abroad, compels us to most vigorous action. We cannot afford in this crisis to continue wasting our greatest resource—the health and strength of our citizens. The major part of the task of making secure the health of the Nation still lies ahead.

Statement ¹ of DAVID S. BURGESS

**Executive Secretary
Georgia State Industrial Union Council
Atlanta, Ga.**

Being a former resident of the State of North Carolina, I am very pleased to learn how much advance this fine State has made. But I think we get a very false idea if we consider the North Carolina figures indicative of the other States in the South. I come from Georgia, and I have made a special study on this whole question of hospital costs and medical coverage, and it is considerably different from the picture here. I think that we

¹ Delivered at the Regional Hearing in Raleigh, North Carolina, August 25, 1952.

are a little more typical, possibly, here in North Carolina, of North Carolina than of the South as a whole.

Number 1, I would like to point out that hospital coverage in Georgia is 23.9 percent, and two-tenths of 1 percent have comprehensive coverage.

Medical Insurance

The Blue Cross coverage in the State is roughly 4.2 percent, and no Negro has yet been able to obtain a Blue Cross policy. There is no Blue Shield in the State. And those having the fortune to have Blue Cross policies find that one policy in one section of the State does not apply to other sections of the State. There are three different systems of Blue Cross coverage. So if I get one policy in Atlanta, but get sick in Columbus, it only covers 50 percent of my normal hospital costs.

Also, I would like to point out that the average industrial worker who earns roughly \$46 a week in Georgia is caught between the insurance companies and the medical profession. Two years ago the Medical Association of Georgia and certain commercial insurance agencies established what is known as the Georgia Plan for medical insurance. The Association set up a rate schedule for surgical operations, and the commercial insurance agreed to incorporate these in their future policies. But the agreement had one major restriction. It stated that if an insured patient earned more than \$2,400 a year as a single person, or \$3,600 a year as a married person with dependents, those rate schedules did not hold in surgical operations.

You can draw your own conclusions as to the rate policies of the problem we have.

In Georgia, we are a low income State, but the doctors on the average earn \$11,259, and the median income is \$8,893. They are very well off compared with the rest of the State.

Last, I would like to point out that in medicine, although we have built 44 hospitals in Georgia under the Hill-Burton Act, only 22 percent of the medical needs for chronic sickness were filled after every hospital built now is considered, or only 50 percent of the needs considering the hospitals now under construction.

Workmen's Compensation

I would just like to point out that we have made a special study of the whole question of workmen's compensation, which is very closely related to this

problem, and we feel after a thorough study of this question that this fact ought to be brought before this group. Over the Nation as a whole, from 1939 through 1948, \$4,750 billion were collected in premiums for workmen's compensation. Out of that, \$2,217 billion or 46.7 percent, actually went out in claims. In other words, 53.3 percent was either used by the company in one way or used in another.

Now, on the question of workmen's compensation, which is related to this health insurance problem, eleven States in America have what is called an exclusive workmen's compensation State fund, in which all the employers of the State are required to insure an employee in the State fund only.

Now, we have made a difference in the study of premium rates on these two types of things between, for instance, one State, Ohio, that has it, and Alabama, that has it. The premium rates in Ohio on a State fund basis are just about 50 percent of the premium rates for workmen's compensation that they have in the good State of Alabama, although the weekly benefits under workmen's compensation in Ohio are between \$30 and \$32, and the weekly benefits in Alabama are only \$23.

We believe that this basis in fact sets us thinking over the whole question of premium rates and the whole question of national health insurance, because we believe that if workmen's compensation is typical, which I do not claim it is, of the amount paid out and the amount taken in—high premium rates in a private insurance company and low premium rates in a State fund—the whole question of national health insurance should be opened for consideration by this group.

Finally, I would just like to read in this conclusion.

After examining these facts about inadequate insurance coverage, high medical costs, and low incomes, the CIO in Georgia has come to the following conclusion. It is our considered opinion that America as well as Georgia needs a system of national health insurance. It must provide the free choice of physicians by the patient and in turn the free choice of patients by the physician.

With national coverage, premium costs per person will be cut greatly and profiteering insurance companies, with their present influence upon the course of legislation, will be forced into more needed channels of free enterprise. Doctors, both specialists and general practitioners, will have

patients who are able to pay for the services rendered them, and in turn no citizen will hesitate for cost considerations to get medical aid in times of need.

Hospitals

Accompanying this measure must be legislative acts designed to increase hospital construction and to provide for adequate training for future doctors and nurses. Specifically, we recommend that the Hill-Burton Act of 1949 be revised back to its 1950 application, which provided that Federal funds should cover two-thirds rather than the present one-third of the costs for new hospitals and renovation of older structures. The cutback from two-thirds to one-third in aid from Federal sources in 1951 greatly curtailed the progress Georgia had made in hospital construction.

Finally, it is our opinion that our Nation would have more reasonable hospital rates and doctors' fees if representatives of consumer groups from civic, labor, church, and women's organizations were given places on hospital boards, county, State and Federal health groups. This should become a Federal policy as well as a local one. For just as wages and profits in industry have quite rightfully become matters of public concern, so hospital programs and doctors' rates have become clothed with the public interest. That is why the workers of Georgia—underpaid, largely unorganized, burdened by a retrogressive sales tax, and hedged about by rising medical costs, plead that the questions of health be taken from the confines of the physicians' closed corporation and be brought out into the open forum of American discussion.

Your Commission is doing this job, and in this you are performing a service for all Americans. You are making real the slogan that public health is the public's business. And the workers of Georgia congratulate you for this important step forward.

(The Prepared Statement of Mr. Burgess Follows:)

The purpose of my testimony is to outline how the average industrial workers in Georgia, under existing medical costs and insurance coverage, simply can't afford to be sick or disabled. In addition, I wish to make certain concrete proposals aimed at bettering the health conditions of every citizen of my native State of Georgia.

Despite rapid industrialization of the South and the artificial prosperity of our present cold-war economy, the average per capita income for Georgia in 1951 was only \$1,103.¹ Georgia ranks forty-second in the United States per capita income.² We are fourth from the top in draft rejections for physical cause, tenth from the top in infant and maternal mortality, and eighth from the bottom in Blue Cross coverage.³ According to the Georgia Employment Security Agency, in June the average production worker in Georgia earned only \$46.24 a week, compared with the national average for production workers of \$66.98 a week.

Low Incomes—High Living Costs

Unfortunately, low incomes are matched by a high cost of living. Six months ago, for instance, Atlanta ranked fourth in cost of living among the larger cities of America. Compared with the base period 1935-39, the cost of living in Atlanta is now at 194.2 in Atlanta, and 202.0 in Savannah.⁴ The U. S. Bureau of Labor Statistics sets the minimum total budget for a family of four at \$4,315 in Atlanta and at \$4,067 in Savannah. These high estimates stand in tragic contrast to the low income figures for average Georgia citizens.

To combat these low wage standards, to eliminate southern wage differentials, and to try to keep with the rising spiral of higher living costs, many workers of Georgia have organized into CIO unions for the purposes of collective bargaining. In every CIO contract we have attempted, with varying success, to incorporate health insurance provisions. Here are a few examples of CIO gains in this regard.

In the textile industry, which still remains as the major employer in the Cracker State, the following health conditions prevail in plants under contract with the Textile Workers Union of America, CIO:

Compton Highland Mills, Inc., Griffin, Ga.

Hospitalization and Surgical Insurance, including dependency coverage. (For above benefits and a life insurance policy worker contributes

¹ U. S. Bureau of Labor Statistics.

² Ibid.

³ "Comparative Health Factor Among the States," American Sociological Review, February 1946.

⁴ U. S. Bureau of Labor Statistics.

22 cents a week, or 44 cents if he has elected to have dependents covered.)

Union Manufacturing Co., Union Point, Ga.

Contributory plan—details not known.

Atlantic Cotton Mills, Macon, Ga.

Hospitalization and Surgical Insurance. (For above and a life insurance and accidental death and dismemberment policy worker contributes 50 cents a week.)

Mary-Leila Cotton Mills, Inc., Greensboro, Ga.

Hospitalization and Surgical Insurance. (For above and a life insurance policy worker contributes 50 cents a week.)

A. D. Julliard & Co., Inc., Aragon Mills Division, Aragon, Ga.

Hospitalization, Surgical and Medical Care Insurance (contributory plan).

Crown Cotton Mills, Dalton, Ga.

Surgical Insurance—noncontributory. Also, company pays one-half of hospital fees of worker and dependents and one-half of physician's fees in maternity cases of a worker's wife.

American Thread Co., Dalton, Ga.

Hospitalization and Surgical Insurance. (Company pays cost of above, except that dividends previously refunded to workers on the part of the insurance program for which they contribute 39 cents a week (namely, a life with double indemnity policy and half of the weekly disability benefit policy) are retained by company to defray cost of hospitalization and surgical insurance and the remaining part of weekly disability benefit policy.)

Celanese Corporation of America, Tubize Division, Rome, Ga.

Hospitalization and Surgical Insurance including dependency coverage. (Company pays whole cost under plan with Prudential Life Insurance Company, \$12.50 allowed for room cost.)

Who Pays for Insurance

At the Southern Spring Bed Company and at the Grinnell Company in Atlanta, the members of the United Steelworkers of America, CIO, have their hospitalization and surgical premiums paid for by the respective companies. Workers and

the company at the Atlantic Steel plant in Atlanta divide the cost of the premiums.

At the two General Motor plants in Atlanta and Chamblee, Georgia, the employees pay one-half of the \$10 monthly premiums for hospitalization, surgical and sickness benefits. The company pays the other half. The policy covers 21 days of hospitalization with a \$12 limit for the day rate. In the event of sickness or disability lasting up to six months or less, workers are paid between \$30 and \$42.50 per week during their period of enforced absence.

The General Motors policy, which has been perfected through the efforts of the United Automobile Workers, CIO, is probably one of the best in Georgia. The Southern Bell Telephone Company, which is under contract with the Communications Workers of America, CIO, offers its employees a hospitalization and surgical policy at a rate of approximately \$1.50 per month.

The Real Cost of Medical Care

Despite these insurance advantages for CIO members in Georgia, no policy covers the real cost of surgery, hospitalization and medicine. Workers at non-union plants are in a poorer condition. They seldom enjoy insurance benefits of any kind, and are, therefore, the victims of the loan shark and of jackleg insurance companies trafficking in weekly premiums and low cost coverage.

Medical costs in Georgia, according to the U. S. Bureau of Labor Statistics, have risen 60 percent since 1939, and 10 percent since the opening of hostilities in Korea. The gap between actual coverage and actual medical costs for the few Georgia workers covered by any form of insurance is widening daily. And the total problem is made more serious by the fact that a great majority of Georgia workers have absolutely no insurance coverage at all.

In the light of these facts, the CIO in Georgia has been forced to reexamine and reevaluate the whole problem of inadequate insurance coverage in our State. We have made an extensive study of the whole problem. These are our conclusions.

CIO Conclusions

(1) Georgia workers know that present health insurance coverage in Georgia is woefully inadequate. In a State with almost three and one-half million residents, only 23.9 percent have partial hospital coverage, 15.2 percent have partial surgi-

cal coverage and 3.3 percent have limited medical coverage.⁵ Only two-tenths of 1 percent have attained the aim of most Americans—that of comprehensive medical insurance coverage. In the first three categories, coverage is approximately 50 percent below the national average. In comprehensive medical coverage, approximately two out of every 100 Americans enjoy these benefits. In Georgia, two out of every 1,000 citizens have them.⁶ The Lehman report gave the following statistics about the number of Georgia citizens having some form of medical coverage:⁷

Hospitalization:

371,700 have group policies.
267,000 have individual policies.
128,039 have Blue Cross policies.
54,187 have other plans.

820,926

Surgical:

397,000 have group policies.
125,000 have individual policies.
0 have Blue Shield Plans.
676 have other plans.

522,676

Limited medical insurance:

46,000 have group plans.
69,000 have individual plans.

115,000

Comprehensive Medical Plans: Total—5,526.

Discrimination and Administrative Confusion

Georgia workers know that Blue Cross coverage is low in Georgia. In September 1950, only 147,056 out of Georgia's three and one-half million citizens had the advantages of Blue Cross, either as an insured or as a dependent of the insured.⁸ Only 4.2 percent of the population were covered by Blue Cross policies, as compared with a national average of 19.2 percent.⁹ Though Negroes make up approximately one-third of the State's population, to date no Negro has been able to obtain a Blue Cross policy.

⁵ Health Insurance Plans in the United States, Report of the Committee on Labor and Public Welfare, United States Senate, May 1951.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

Unfortunately, a few Georgia citizens with these policies are the victims of administrative confusion. For in Georgia there are three separate Blue Cross plans centering in Atlanta, Columbus, and Savannah, respectively. Each plan is different. Each operates independently of the other. This works to the disadvantage of every subscriber.

If I take my policy out with the Atlanta group, for instance, but break my leg and am hospitalized in Athens or some other town, my Atlanta policy will pay about 50 percent of my average total daily rate of \$14.85¹⁰ in Georgia as a whole. If I am forced to go to one of the three Atlanta hospitals not covered by the plan, only \$8.50 of my average daily expense of \$18 in Atlanta¹¹ would be paid for by the Blue Cross plan. If I am hospitalized in one of the 44 rural and small-town hospitals built under the provisions of the Hill-Burton Hospital Construction and Survey Act, again a small percentage of my total daily cost would be paid by the Blue Cross policy.

Fortunately, the Blue Cross group in Columbus, which is now the second largest in the State, is selling a policy to cover up to \$12.50 of the total daily expense in most Georgia hospitals. This will help those rural residents who are able to pay the high premium costs for such policies. Yet even under this improvement, out-of-State residents having Blue Cross policies will find that their policies cover only a fraction of the real hospital costs if they have the misfortune by accident or other circumstances to be hospitalized within the bounds of the State of Georgia.

This "balkan" confusion calls for reform by the leaders of the Blue Cross groups. The poor coverage hurts not only the average Georgia policy holder, it also lends aid and comfort to the enemies of the Blue Cross system.

Medical Costs—Adequate Protection

In matters of medical costs and adequate protection, the Georgia worker is caught between the insurance companies and the medical profession. Two years ago, for example, the Medical Association of Georgia and certain commercial insurance agencies established what is known as the "Georgia Plan for Medical Care Insurance." The association set up a rate schedule for surgical operations

¹⁰ Estimate of \$14.85 from publication of American Medical Association, June 1952.

¹¹ Estimates furnished by Hospital Services Section, Georgia Department of Public Health.

and the commercial insurance agencies agreed to incorporate this schedule into their future policies. But the agreement had one major restriction. It stated that if an insured patient earned more than \$2,400 a year as a single man, or \$3,600 a year as a family man with dependents, then the surgeon or doctor in question could raise his rates arbitrarily above the scheduled rates.¹²

This system worked a great hardship on one of my friends who had the misfortune of earning more than \$3,600 a year. He had his appendix removed, thinking that the \$100 in his policy would cover the full cost. The doctor, however, chose to charge him \$150, and under the Georgia plan he could have set a still higher fee. My friend objected, but without result. He went away from the hospital convinced that all doctors charged "what the traffic would bear," and that in order to make up for their charity and low-income cases they purposely overcharged those with higher incomes and with known insurance policies.

Though he may have been too sweeping in these generalizations, the fact remains that surgical and hospital rates, which are determined solely by professional physicians and administrators without consultation with medical consumers, are highly subject to change. Consequently, even the best insurance policy of today with a set schedule for surgical and hospital rates will not cover the medical costs of tomorrow.

The Georgia worker knows, moreover, that Georgia doctors in a State where average per capita income is very low, have not suffered under the existing system. According to the United States Department of Commerce, the average income for Georgia doctors is \$11,058 a year, which is only \$201 less than the national average of \$11,259.¹³ The median annual income is \$8,893.

Commercial Insurance

At the same time, the commercial insurance companies—whose major center in the southeastern United States is Atlanta, Georgia—are profiting from their cooperation with the medical profession. Having some association with the Georgia State Legislature, I can testify to the fact that the insurance companies of my State have ample

money to spend and proven ability to influence the course of legislation.

After making a thorough study of one branch of legislation—that of workmen's compensation—I am convinced that in the general field of health and accident insurance the great difference between the premiums collected from employers and workers on the one hand and the relatively small outlay in the payment of claims on the other, accounts for the extensive influence of the insurance company representative in influencing legislation. This is certainly the case in the matter of insurance companies carrying workmen's compensation policies, as I will outline in section 5 of this testimony.

Hospital Facilities

Georgia workers suffer from a lack of hospital facilities. Despite the liberal use of funds provided by the Hill-Burton Hospital Construction and Survey Act, the building of new structures has only scratched the surface of the total health problem. According to the Georgia Department of Public Health, 44 new hospitals with a total number of 2,192 beds had been built by July of this year. Yet this new construction met only part of the needs. The following chart sets forth the facts about estimated hospital needs of Georgia:¹⁴

Category	Existing and under construction	Number of beds needed	Percentage of needs already met
			<i>Percent</i>
General.....	7, 988	15, 380	52
Nervous and mental.....	10, 924	17, 090	63
Tuberculosis.....	2, 208	2, 445	90
Chronic.....	1, 516	6, 836	22

Partly because of the domination of State politics by the two-unit counties, to date new hospitals have been built almost exclusively in the rural areas. City hospitals have not yet reaped the benefits of the act, although 45.3 percent of Georgia's population lives in areas now classified as industrial. In Atlanta, for example, 9 out of the 10 existing hospitals in use can be classified as old and run-down. The only first-rate establishment is the newly constructed Hughes Spalding Pavilion of the Grady Hospital, which serves only Negroes who are able to pay their way. Charity patients need not apply.

¹² Information from Sydney Wrightsman, Publicity Director, Medical Association of Georgia.

¹³ U. S. Department of Commerce, Dr. Wm. Weinfeld, "Income of Physicians," May, 1951.

¹⁴ Georgia Hospital Statutes of 1952, Survey and Planning Section, Georgia Department of Public Health.

New Hospital Construction

The construction of a new hospital, moreover, whether it be in a remote two-unit county or in a thriving metropolis, is now a relatively easy task. The matching provisions of the Hill-Burton Act make this task easier, the governors of Georgia, eager to claim credit for every new structure, are quick to get Federal aid for such construction.

But in reality the construction of a new hospital in a community only lays bare the basic insurance needs of that community. In one small rural town of Georgia, for example, a hospital with 40 bed facilities incurred a deficit of \$20,000 during its first year of operation. This condition arose because 30 percent of the patients couldn't pay their bills. Few had high incomes. Fewer still had health insurance policies.

The hospital's Board of Control, made up exclusively of doctors and surgeons, is now faced with a puzzling financial question: shall they increase their fees and hospital rates, thereby making the more fortunate citizenry pay the bills for the less fortunate? Eventually, I am sure, the members of this board, as well as the citizens of that area will realize that a hospital cannot serve a community unless the citizens are properly insured against sickness and disability, and that doctors can't be paid and hospitals can't be maintained unless this is the case.

In surveying the cost problems of 12 new hospitals which had operated for one year in 1951, the Georgia Department of Public Health discovered that hospital and surgical coverage varied between 2 percent in one to 50 percent in another. Twenty-eight percent was the average number of patients who had policies in these new hospitals.¹⁵ And as new hospitals are completed under the provisions of the Hill-Burton Act, the problem of health insurance, I am sure, will loom more and more important.

Revision of Related Laws

Georgia workers find that no health plan can be complete, or even partially adequate, without a thorough revision of related laws. For instance, existing Georgia laws for public assistance make no provision for medical costs in determining the minimum family budget for destitute cases. No provision for medical costs, furthermore, is made

by Georgia laws which set \$20 a week for 20 weeks as the maximum payment for men and women unemployed through no fault of their own.

Imagine what would happen to the medical care of the unemployed in the event that the cold war ends and mass unemployment results. In 1952 no provision for medical costs is made under Federal or State laws for those who are disabled wholly or in part, since under existing statutes old age and survivors insurance can have no application to those who are temporarily disabled.

Georgia workers, however, regard their State Workmen's Compensation law as the most glaring example of governmental irresponsibility in regard to medical costs and coverage. Starting out as a genuine measure to improve the lot of workmen killed or injured on the job, the Georgia workmen's compensation law, like nearly every other State compensation law in the United States, has deteriorated into an act designed to limit the liability of employers and to cheat the employee of his rightful due. This fact is especially true in regard to the meager guarantees of medical cost coverage in the existing workmen's compensation laws.

Below is a chart outlining the low medical coverage of State workmen's compensation laws in southeastern States:¹⁶

State	Maximum	Time Limit
Alabama.....	\$500	90 days.
Georgia.....	750	10 weeks.
Louisiana.....	500	
Tennessee.....	800	6 months.
Virginia.....		60 days.
South Carolina—Administered by administrative authority.		
Mississippi—Fee schedule in statute.		
Florida—Administered by administrative authority.		

Workmen's Compensation Policies

Most employers in Georgia, as in other southern States, carry workmen's compensation policies with private carriers. Under these circumstances, these private insurance companies fight almost every claim filed by the workmen. In addition, the private insurance companies pay back only a small percentage of the total premium payments in claims.

¹⁵ Information from Director of Hospital Services, Georgia Department of Public Health.

¹⁶ U. S. Bureau of Labor Statistics.

As shown in the July 1950 issue of the Social Security Bulletin of the Federal Security Agency, during the period of 1939 through 1948, private carriers in the United States collected \$4,750,-600,000 in insurance premiums. They paid out only \$2,217,100,000 in claims, or 46.7 percent in all. This meant that 53.3 percent went for administrative costs, corporation profits, lobbying expenses in influencing national and State legislatures, expensive investigatory and legal staffs, which specialize in delays, appeals, and other obstructionist tactics. In any man's language, this is an exorbitant rate of profit.

State Fund

In contrast to this high profit rate for private carriers of workmen's compensation policies is the exclusive State fund system for workmen's compensation which is now operative in 11 States. This system reduces cost to the employer in premium rates. As proof of this point, contrast the cost of compensation to the employer in certain specific lines of manufacturing.¹⁷ The first is in Alabama, which has a weekly maximum of \$23 a week for workmen's compensation; the second is in Ohio, which has a weekly maximum ranging between \$30 and \$32.20:

Specific Manufactures	Premium Rates	
	Alabama	Ohio
Steel manufacturing.....	1.77	.95
Steel fabricating.....	1.60	.85
Machine shops.....	1.38	.45
Auto manufacturing.....	1.11	.45
Rubber tire manufacturing.....	2.23	.55

The difference between the rates can be attributed to one fact alone: Ohio has the exclusive State fund system for workmen's compensation, while Alabama allows employers to be self-insurers or to deal with private insurance carriers. Considering the fact that 1 percent of the State workmen's compensation funds in Ohio is set aside for safety and hygiene and \$2,500 million is provided by the State for administrative purposes, 90.7 cents of every premium dollar paid into the State fund by an Ohio employer is plowed back into workmen's compensation payments.

¹⁷ Ohio Industrial Commission, "Workmen's Compensation and Employers' Liability Manual."

Contrast this figure with 46.7 cents out of every premium dollar paid out by common carriers, and the case for the exclusive State fund is more or less proven. Then apply this same formula to the whole question of premium costs for health insurance, and the case for national health insurance as over and again the present patchwork confusion is made plain to every American.

Those Least Able to Pay

In Georgia, which is a low-income State, the heaviest burden falls upon those least able to pay their bills. According to the National Health Survey of 1939—whose findings, according to the Georgia Board of Health, still have general application to the State of Georgia today—the families earning a total of \$3,000 a year pay about 6 percent in total medical expenses, including physicians' expenses, hospital costs, medical bills. Those earning less than \$2,500 pay around 10 percent for these same expenses. But a person earning \$10,000 or more has medical bills varying on the average between 1 percent and 4 percent. Thus, the major burden for medical expenses falls upon those American citizens least able to pay.

The lower income families of Georgia, moreover, do not only bear a proportionately larger percentage of the medical costs. They also suffer from the undeniable fact that many doctors and many hospital administrators have put the all-mighty dollar before the treatment of needy men and women.

Last winter there appeared in an Atlanta paper a story about a southern mother who called upon a doctor to treat her child sick with pneumonia. The doctor refused to come to the house because the woman could not pay for his visit. In the snow, the woman then carried her child to the next town for help. The baby died. The county medical association defended the doctor's refusal on the grounds that the medical profession is after all a business venture.

Such incidents happen in Georgia frequently, especially in the rural areas. In the cities the same type of refusal often occurs in a more sophisticated form. Many hospitals will not admit a patient who cannot show he is covered by hospitalization insurance unless an advance payment is made or he can produce tangible evidence that he is able to pay.

The other night a small child in my neighborhood was run over by a truck and critically in-

jured. The family had a very low income. They were forced to go from door to door to try to raise the \$300 fee demanded in advance by the surgeon the hospital wished to summon. And after that incident, I know that my testimony before this committee today must deal not only with cold and sometimes convincing statistics—but also with the human side of our gospel of national health insurance.

* * * * *

Federal Legislation Proposed

After examining these facts about inadequate insurance coverage, high medical costs, and low incomes, the CIO in Georgia has come to the following conclusion. It is our considered opinion that America as well as Georgia needs a system of national health insurance. It must provide the free choice of physicians by the patient and in turn the free choice of patients by the physician.

With national coverage, premium costs per person will be cut greatly and profiteering insurance companies, with their present influence upon the course of legislation, will be forced into more needed channels of free enterprise. Doctors, both specialists and general practitioners, will have patients who are able to pay for the services rendered them, and in turn no citizen will hesitate for cost considerations to get medical aid in times of need.

Accompanying this measure must be legislative acts designed to increase hospital construction and to provide for adequate training for future doctors and nurses. Specifically, we recommend that the Hill-Burton Act of 1949 be revised back to its 1950 application, which provided that Federal funds should cover two-thirds rather than the present one-third of the costs for new hospitals and renovation of older structures. The cutback from two-thirds to one-third in aid from Federal sources in 1951 greatly curtailed the progress Georgia had made in hospital construction.

Hospital Rates and Doctor's Fees

Finally, it is our opinion that our Nation would have more reasonable hospital rates and doctor's fees if representatives of consumer groups from civic, labor, church, and women's organizations were given places on hospital boards, county, State, and Federal health groups. This should become a Federal policy as well as a local one. For just as wages and profits in industry have quite rightfully become matters of public concern, so

hospital programs and doctor's rates have become clothed with the public interest. That is why the workers of Georgia—underpaid, largely unorganized, burdened by a retrogressive sales tax, and hedged about by rising medical costs, plead that the questions of health be taken from the confines of the physicians' closed corporation and be brought out into the open forum of American discussion. Your Commission is doing this job, and in this you are performing a service for all Americans. You are making real the slogan that public health is the public's business. And the workers of Georgia congratulate you for this important step forward.

Statement¹ of

MR. ROBERT HESS

President

Minnesota State CIO Council

Minneapolis, Minn.

The local union I represent has a full coverage plan that pays \$9 per day, up to 70 days, for any one disability; a surgical schedule of \$150 and doctor calls in the hospital.

Now let's look at what has happened to all of this since September 1950, when it was made part of our union agreement. Let's see what has transpired since that date. Ward charges in the hospital averaged approximately \$10.50 per day. Today the same facilities cost one from \$12.50 to \$13.50 per day, so you see the people I represent are relatively less better off than they were 2 years ago.

I have here a copy of a hospital bill from the Charles T. Miller Hospital in St. Paul, Minn. It was a bill picked at random from the many we have in our possession. This individual was forced through circumstances beyond his control to accept a private room at a cost of \$20 per day. He spent 10 days in the hospital at a total cost of \$309. Of that amount, the plan described above paid a total of \$186, leaving him a balance of \$123.

Needless to say, this man had to procure the money to pay his share of the bill from a loan agency. Experience has shown us that the plan negotiated in 1950 paid approximately 85 percent of the hospital costs in 1950—just the hospital

¹ Delivered at the Regional Hearing at Minneapolis, Minn., September 2, 1952.

costs—while it pays above 70 percent of the average hospital cost today.

We no longer press for increased amounts of coverage for the daily hospital expense benefits. The reason for this, of course, is the constant rise in hospital rates. Rather, we seek to have plans that pay for semi-private room coverage, or even private room coverage, thus the increased rates that the hospitals charge do not affect the plan.

We can then have room coverage, and if they increase the rates, it does not increase our plan. Unfortunately, the one we have in effect has slipped to 15 percent of the coverage.

The conversion features of the plan I have described are also inadequate. There is just a 3-month carry-over after an employee is separated for one reason or another. There is no conversion privilege to a permanent individual plan. Even so, the individual plan would cost much more money and would have less benefits.

This, then, leaves the worker who may be laid off, or separated from his employment for any reason, without hospitalization whatsoever after the 3-month termination period.

Surgical Costs Mount

We find surgical costs increasing. In 1950, the average maternity charge was in the neighborhood of \$60 in the St. Paul area. Today we find that to have increased to \$85, again in the St. Paul area. Maternity is by no means the worst example of increases in the doctor's charges. The plan we have in effect pays on their surgical schedule \$50 for each maternity. But, as I say, maternity is by no means the worst example of increases in the doctor's charges.

My experience has shown that the type plan we have pays an average of from 50 to 60 percent of the physician's actual charge. For years it has been assumed that a doctor would accept as payment in full the amount listed in the payment schedule, if the employee earned \$3,000 or less per year. It is only the occasional employee who earns less than \$3,000 per year at the plant in question. It is only the occasional doctor who accepts as payment in full the scheduled benefits from these people earning more than \$3,000 per year.

Therefore, you see, as in the case of the daily hospital charges, our people are caught in the squeeze.

For all of the reasons outlined above, plus the fact that the multitude aren't even covered by any type of voluntary plan, I must take the position that voluntary plans are just not good enough. They have a demonstrated inadequacy. The only answer, as I see it, is in some type of compulsory prepaid health insurance. Whether this be contributor or not is another question. I think, though, that the ultimate answer lies in that direction.

Statement¹ of

OSCAR A. EHRHARDT

Secretary

CIO Industrial Union Council

St. Louis, Mo.

The St. Louis Industrial Union Council, CIO, representing some 65,000 wage earners in St. Louis, St. Louis County, and including parts of St. Charles County, joins others in the interest of a national health program for our Nation's people.

We have long recognized a serious need which becomes more pronounced as time goes on. The need not only exists among our membership, but it embraces the large majority of our Nation's citizens.

We recognize the need for more doctors, dentists, hospital beds, nurses, and medical research. It requires days to make a test to determine malignancy when minutes are important, at least, important to the individual and his family. An appointment with a dentist calls for a 6-month waiting period. M. D.'s enter into medical pools to secure relief from the constant demand for their services.

It is significant to note that this hearing, being held in one of the recognized medical centers of the world, finds the people in this area, who undoubtedly are in a better position to receive medical and dental attention, yet even here we find medicine in all its categories inadequate to meet the needs.

Preventing Disease

Industrial disease takes its toll each year, and for the most part is accepted as part of the game, when we know full well that many of these

¹ Delivered at the Regional Hearing in St. Louis, Mo., September 15, 1952.

diseases can be prevented. Workmen's compensation programs are not the answer. At the best they provide little comfort.

We believe it to be pure folly to concern ourselves only with curative medicine, when oftentimes diagnostic and preventive medicine are equally or more important.

Many individual cases can be cited, setting forth information to prove the point that illness has caused not only the loss of wages and savings, but oftentimes causing families to go heavily in debt. They all can only point to the cost in dollars and cents and, as important as this is, what to us is more important is the lack of concern to make any attempt to prevent the many illnesses by providing proper attention. Innumerable heads of families have knowingly bypassed this phase of medicine not only because of the initial cost of check-ups, but because of the consequences. Rather than to determine through diagnosis the curable illness they may have, they have chosen to carry on through suffering because of the cost involved in curative medicine. These costs would deprive their families, and reduce their standards of living, sometimes to a breaking point.

Protection Against High Costs

Many years ago, some of these factors were recognized in some circles, and a method of prepaid hospitalization was established, not only to provide prepaid hospitalization, but also to guarantee payment to the hospitals. It filled a much-needed gap in this phase of protection; however, it was woefully lacking in filling all the needs which were present.

Labor unions, cognizant of these other needs, gave leadership to providing health plans through the system of collective bargaining. While these programs have been most beneficial they also are lacking in many respects.

People today find we are living in an era of specialists. Of the approximately 152,000 physicians in active private practice, 45,000 are specialists. We can see the merit of specialization and know the advantages of expertness, but it adds to the cost of illness to a point which most people can ill afford to meet. These necessary costs must be met in some fashion. Rural areas are hard pressed for decent medical care. While some cities have one M.D. per 500 persons, 10 percent of all counties in the United States have less than one

active M.D. per 3,000 persons. Seventy-five counties have no active M.D. at all.

We do not quarrel with the medical profession, but to the contrary, laud their many accomplishments. Individually, doctors are extremely sympathetic and mankind is the benefactor, but collectively, they present a menace to society. This labor organization has no interests or sympathies with socialized medicine, but a national health program is one of our most desperate needs.

Appalling Doctor Need

We feel that the need for more doctors is appalling, and little being done to correct this serious condition. We find it difficult to understand the call for private grants and endowments to universities for the teaching of medicine, knowing full well that these funds are subject to tax exemptions. Further, they do not relieve the costs in and tuition to the individual which prevents many potential doctors from learning this profession.

While it is not my intention to quote statistics, as I know the Commission has plenty of factual material, I think it worth mentioning that, nationally, we have only one medical man for every 950 American people. Also worthwhile to mention is that by 1954 our Nation will witness a shortage of some 22,000 physicians.

While the quality of medical education has improved, we are training fewer doctors in proportion to our population today than in 1910. Only 14 counties in every 100 throughout the Nation meet the minimum standard of 4½ general hospital beds per 1,000 population. We cannot reconcile ourselves to the fact that over 15 times more money is spent per year for industrial research than for research and development in medical and allied sciences; \$2 million more is spent for research in plant and animal disease than for human disease.

Mr. Average Citizen

We are concerned with Mr. Average Citizen whose heart is filled with constant fear of loss of income and the terrific cost of medical attention. When we think of the people next door, or across the street, who through their productive years secured a small home and a meager sum to carry them through the autumn of life, spending their savings and mortgaging their homes to pay the cost of old age, we wonder if nothing better can be provided.

We do not want charity or sympathy. We do want a sensible plan of prepaying our medical and hospital costs—a program of, by and for American people—an all-inclusive program of benefit to all regardless of their station in life or their geographic location.

Statement¹ of

MR. ED MURNANE

Sub-Regional Director

U.A.W.-C.I.O.

Milwaukee, Wisconsin

My name is Edward Murnane. I appear here as the Sub-Regional Director of the United Automobile Workers of America, C. I. O., and on behalf of the members of this union in Minnesota and North Dakota.

* * * * *

American workers are determined to secure protection as a matter of right against unpredictable health costs. Our international union, the UAW-CIO, since the middle of 1948, has negotiated prepaid hospital-medical protection covering over 3 million people—more than a million workers and 2 million dependents. We had to do this because voluntary prepaid health insurance plans just did not, do not and will not do the job of insuring against the high costs of illness.

It should be a matter of record here that benefits paid in 1951 alone under the health security programs negotiated by the U. A. W. amounted to more than \$125 million. Of this total, \$50 million was paid for hospital services, \$23 million for physicians' services, a total of \$73 million; and then \$52 million was paid in cash income maintenance and life insurance benefits. Our members in this area are covered under these plans and received a part of the benefits that I have mentioned.

Additional Fees for Surgery

Even so, our experience in this area, as in others, has clearly indicated that our members, and all other workers who also have some form of health insurance coverage, are not receiving full value on their surgical insurance because of the growing practice of charging additional fees for surgi-

cal operations, fees which are over and above the payments provided through surgical insurance.

Hospital insurance coverage has proved somewhat more adequate in this respect, but today increased hospital costs and abuses in some hospitals of the fee and charges system threaten to decrease the value of what hospital insurance is available.

On the item of surgical schedules in our contracts, we no longer press for increased schedules of payment. Why? Because surgical charges made against our members are raised as fast as, or faster than, the payment schedules.

Most insurance against the cost of surgical care is provided on a cash indemnity basis. The contract is between the insured and the insurance carrier—the doctor is not a party to the agreement and is, therefore, free to charge more than the scheduled amount.

Our experience has shown that doctors commonly charge more than the scheduled allowances provided through insurance. A recent study made by the Actuarial Society of America analyzed 100,000 surgical claims, and concluded that surgical insurance covered, on the average, only 55 percent of the doctors' charges.

In one of our U. A. W. studies we found that the surgical schedule was most nearly adequate when it came to minor operations, but that for the more expensive operations—when our men and their families most needed financial protection—the doctor's charges exceeded the schedule allowance on more than nine out of ten cases.

Increasing surgical schedules under these circumstances—and that is what many voluntary plans are trying to do—represents nothing more than "built-in-inflation", and is no substitute for a full-payment service program at reasonable cost. The same thing is true, in lesser degree, of attempts to liberalize in-hospital medical benefits, and the adoption of home and office medical benefits.

Voluntary Plans Cover Only Employed

Another very serious deficiency of these voluntary plans, as I see it, is that the workers remain protected only while they remain employed. When a worker is laid off, retires, or is otherwise separated from a group, the protection that his family has under the program very soon expires.

Under commercial group insurance plans there is generally no provision for conversion to individual health insurance plans.

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

Under Blue Cross and Blue Shield plans, conversion is possible, but the benefits are usually greatly reduced, age and other restrictions imposed, maternity benefits especially curtailed and, furthermore, the premiums for individual coverage are often not only substantially increased, but they must also be paid several months in advance—a large chunk out of the pocket of an auto worker receiving \$20 to \$25 weekly unemployment compensation benefits, or the average pension of approximately \$110 a month.

We have found another serious deficiency in the voluntary plan coverage: These plans just do not cover what often amounts to a sizeable amount of money annually; the relatively small doctor, drug and hospital bills not covered by the insurance. These costs, as I have found by painful personal experience, can total quickly to an extremely heavy burden. It is a burden which definitely lowers the standard of living for thousands of people supposedly adequately covered by health insurance.

There are many other facts which we could present today about the health needs of the people of this area:

That facilities and health personnel are unevenly distributed throughout the area, leaving many persons with still less or no protection than we have in the Twin City area.

That there is an alarming shortage of facilities for mental patients.

Now, in conclusion, I would like to present very briefly a case history telling the story of hardships because of inadequate coverage . . .

We have many more such cases. . . .

CASE HISTORY:

Ralph Broman

My name is Ralph Broman. I live at 3328 31st Avenue South in Minneapolis. I work at the Donaldson Co., 666 Pelham Boulevard, in St. Paul, and am a member of Local 41 UAW-CIO. I am married and have four children.

During the last 23 years I have had progressive paralysis in one part of my body and another. . . . Last year I was forced to quit work and, under doctor's orders, had to stay home for 6 months.

The only income during this time was \$25 a week from my health insurance (John Hancock Co.) during the first 3 months I was off. After that I

had no help from the insurance, which was not of much help even when I was getting it, and so I drew all my profit-sharing savings of \$200 from the company where I work. In addition to this, the men at the shop took up a collection for our family of about \$200.

I also had Blue Cross, Blue Shield, but on medicine alone these policies failed to cover \$129 of the cost. In addition, I lost wages amounting to \$1,044. As a result, we are still pretty much in debt.

I am able to work 4 days a week now, but if I get another attack I wonder what will happen. I do own my house, but if I am forced to quit work again, with all the debts I owe now, I am afraid I will lose even the house.

Statement¹ of SOLOMON BARKIN

**Research Director
Textile Workers Union of America
New York, N. Y.**

We are appearing before your Commission on behalf of the organized textile workers who can testify on the inadequacy of the present medical care programs provided throughout this country.

We want to state at the outset that the largest proportion of our 400,000 membership is now covered by a medical insurance program which usually provides for hospital coverage through the Blue Cross or service programs, or through insurance programs reimbursing persons for expenses incurred during hospitalization.

The provisions in such programs commonly provide for hospital incidentals. Most of our plans provide surgical benefits, either through Blue Shield or traditional insurance. A substantial proportion of the insurance policies extend benefits to dependents. Less than half of our programs provide reimbursement for medical expenses in the form of payment for doctor's treatment.

We wish to affirm that the development of these measures has been a necessary incident to the increased security of the textile workers.

Serious Challenge

The cost of such medical attention has in the past

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

presented a serious challenge to the textile worker. It was a financial drain for which he was not usually prepared; medical care customarily represented a burden he could carry only by going into debt. He either borrowed from commercial loan companies and paid exorbitant rates of interest or he borrowed from friends or relatives. The result was that much necessary medical care was not secured. The proficiency of workers and their physical capacity was thereby considerably reduced. These programs have been widely welcomed by the workers in the industry.

The initiation of such programs has, however, exhibited clearly the inadequacies of present facilities as well as highlighted the prerequisites for more constructive action in the future.

The first outstanding fact is that the present programs are highly inadequate in covering the expenses of most illnesses. These inadequacies are particularly evident in the case of the insurance programs which do not undertake to cover the entire cost of the particular medical need. In the case of hospitalization, hospital rates have risen recurrently during the last years.

The protection provided by insurance provisions in our collective bargaining contracts has been lagging behind these increases in costs. Consequently, the worker has had to supplement the reimbursement from the insurance companies. Fortunately, the Blue Cross programs have been more satisfactory in this respect, since the worker covered by such programs knows that the services will be rendered and no additional financial responsibilities will follow. At the present time the worker who uses the hospitals or the surgical care finds much to his surprise that insurance benefits are inadequate to cover his out-of-pocket costs.

Service Programs

These deficiencies have been particularly pronounced in the case of the surgical fees granted under insurance policies. The medical profession in this field has learned that it could use the fees spelt out in the fee schedule as a jumping-off plank for raising their total fees. They have not accepted these fees as final and have become practiced in asking workers for additional sums over and above those set forth in the schedule. This practice has widely outraged our membership.

There is a general conviction that the doctors have been engaging in a hold-up, exploiting the gains secured by workers through their economic

power to stage another raid on their incomes. Incidentally, Blue Shield is much more satisfactory because it provides and pays for full service.

Experience with both the hospitalization and the surgical programs highlights the importance of extending the service types of program instead of the reimbursement of indemnity type now provided under private insurance programs. To the extent possible, our organization has pressed for these service programs. But the employers have not been uniformly interested in the quality of the protection provided their employees. They have listened to the counsel of insurance brokers or to friends interested in their business and commissions. We have also found employers who, imbued with the need of fighting all nonprofit organizations, have preferred to assign their policies to private insurance companies.

The least satisfactory programs in which we have participated are those providing for indemnities for medical care through payment for hospital visits. This provision has been most inadequate because the fee schedule, as in the preceding two cases, has been used to raise the total charge. Doctors have regularly insisted upon supplementation.

In the second place, customary restrictions placed upon the occasions when such medical care were provided are so sweeping that the program largely fails of its purpose. Narrow limits of circumscribing the types of services provided has discouraged use of the service. Too many workers have had the experience of expecting medical benefits only to find that the particular ailment and circumstances do not come directly within the purview of the contract. This type of experience has caused disgruntlement and discouraged use of the plan. The consequence has been failure to improve health.

Adequacy of Coverage

The medical programs have also suffered by not being preventive in character. Workers need a system of medical attention which will provide complete service. They must have clear instruction in self-administered treatments and care. Consultation and diagnostic attention are now completely lacking. There is no interest in education.

As a result of the widespread dissatisfaction now prevailing with these medical indemnity programs, we, as a union, have favored the develop-

ment of the other types of medical benefits under insurance programs. We do not believe that the present medical benefits are adequate or properly conceived. They are the weak spot.

In contrast to the above we may cite the widespread satisfaction with the service program provided by the Health Insurance Program of New York City. Many of our contracts in the Metropolitan New York area incorporate this service. The greatest satisfaction has been revealed with the type of service, quality of medical attention, and adequacy of coverage.

Many of our members have been vocal about the advantages of this type of service. They approve of the extent to which it has provided them with medical care and relieved them of all financial concern about possible costs. The completeness of the coverage has been recurrently disclosed by the easy availability of HIP facilities to treat even unusual types of problems, and to cover the costs of these non-routine cases. The competency, friendliness, and interest of the medical staffs have been widely approved.

Indemnity Type Program

The advantage of the indemnity type of program has become particularly striking as the specialist type of medical practice has become more common. This system of medical care provides service in two stages, preliminary review by a general practitioner and referral to a specialist. Hence, costs have mounted considerably. The indemnity type of insurance is insufficient for this form of medical practice. Moreover, it does not recognize its existence. The indemnity method is actually obsolete.

In order to provide for such rounded diagnostic, clinical, and therapeutic attention, it is necessary to organize group practice and to centralize facilities. Such arrangements are not encouraged by present types of indemnity programs. The advantages of such care have been repeatedly disclosed during our experience with the Health Insurance Program of New York City; advantages unparalleled in any of our other locations.

One primary deficiency has been in the inadequacy of coverage for unemployed workers. We have pressed strongly to have the coverage extended beyond the customary 30 days. A number of our employers has agreed to shoulder the cost of more liberal coverage, but this is unusual.

Obviously, the present types of hospitalization and medical service fail when the financial capacity of the worker to meet the cost is lowest. The present programs are for the employed and not the unemployed. The situation becomes particularly aggravated when the unemployed is an older person. For older people, medical and hospital needs are great and opportunities of securing employment are lower. The present programs make no provision for these people.

Shortcomings

Other abuses have been pointed up by our members. One abuse heard repeatedly is that doctors have been compelling workers to come to their offices for an excessive number of visits. Some doctors have been unwilling to fill out forms required by insurance companies unless patients visit them at their offices and pay a regular fee. This practice has outraged many textile workers.

In conclusion we wish to note the following:

1. A substantial proportion of textile workers who are unorganized are not now covered by any type of medical benefits. In the cotton textile industry, 36 percent are covered by no health insurance program and 28.3 percent by no form of hospitalization insurance.

2. Unfortunately a substantial proportion of the persons covered find the insurance inadequate in face of rising fees and charges and the deliberate effort on the part of doctors to hike their fees for surgical and medical attention above those specified in the insurance schedules. Other abuses exist, such as the insistence of excessive numbers of visits in the case of medical care. Over-all, the indemnity programs suffer by tending to cover a small proportion of the real out-of-pocket expenses for medical attention both at the hospital and at home.

3. A service program for hospitalization and surgical care is most satisfactory and assures the most adequate coverage by workers.

4. The present indemnity programs for medical care are of highly questionable value. Their coverage is limited, their benefits inadequate, and the type of medical care they promote will not assure healthier persons. In their place a more complete system of medical attention is necessary for the textile worker which will be

built on the same service principles now enjoyed by our members in New York City under the Health Insurance Program of New York City.

5. The system of protection should be extended from the employed to the unemployed person. The high rate of industrial turnover makes such protection imperative. The worker is in greatest need of protection during such period of unemployment. No provision is now made for such care.

**Statement¹ of
MR. GEORGE DEAN
President
Michigan Federation of Labor
Lansing, Michigan**

Obviously you are not going to get a learned dissertation on the medical need of services in this State from me. What I am going to attempt to do is show some of the outstanding needs that are so apparent. * * *

First I want to make some comments about health in the home. It would seem to me a healthy mother is the keystone of the home. And we note in the report from the Commissioner of the Detroit Department of Health that Detroit's infant mortality rate, after a long period of decline, is now on the increase, having increased 15 percent during the first six months of 1952 from the same period in 1951. This information is given in percentages rather than numbers, and when we consider the increased population, the information is alarming—an indication of shortage in health personnel, the inadequacy of public health units, and increased need of medical research and medical services in connection with motherhood.

Local communities have the responsibility to see that children attending school are free from disease, that they hear and see properly, and have a noon lunch.

I think those are basic needs.

The health of our children has been improved with the services provided in some of our local schools, such as school nurses, periodic examinations and noon lunches. This service should be expanded to where it is provided to all school children in the State.

At work: Mention has been made of the medical service to protect the health of our children at school, and the need to maintain and expand those services. Improved services for the protection of the health and safety of the breadwinner during employment are a "must."

During the past decade much has been done to improve the working conditions affecting the health of the worker. Much remains to be done.

Industrial Health Protection

The changes in production methods, properties of materials used, and industrial processes are continually increasing the need for industrial health protection.

It is generally agreed that providing a safe place to work is the responsibility of the employer. It needs to be emphasized that safety includes those hazards which insidiously affect the health of the worker, which generally can be classified as atmospheric pollution, and conditions of employment which cause such physical breakdown as hernia.

In some communities services through the local health department are available to employers to guide industrial health programs in local places of employment.

The Michigan Department of Health provides similar services. That there is room for improvement is indicated by the report for the months of January through April 1952 by the Michigan Workmen's Compensation Commission which includes only employers of four or more and therefore not complete. The report shows 356 cases of industrial disease and 1,262 cases of hernia, or approximately 16 percent of the total of approximately 10,000 injuries reported.

Of course I could enter into a long dissertation on the Workmen's Compensation Law and its shortcomings but in these two particular cases it is difficult to establish that the injuries arose out of and in the course of employment. It is a tremendous problem to the individual who is faced with carrying on his home when he gets this type of injury.

There is a great need for the expansion of the medical services in the smaller plants particularly, both as to the prevention of industrial disease and hernia, and also as to industrial nurses and first aid. Much of the responsibility for seeing that these are provided rests with the local health department.

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

I do not mean that it all rests with the local health department but I do feel they should be the spearhead of activity which brings about understanding of the need for these services and the methods of combatting and eradicating them.

In these days of atmospheric control both as to temperature and content, there is little excuse for permitting this kind of atmospheric pollution to continue.

What the Record Indicates

In summary we believe the record indicates current shortages in health services generally, including personnel and research.

We believe in general the people are in a much more favorable position because of the various health insurance plans to those situated who cannot afford such health insurance. This leaves far too many unable to carry this protection or sustain with their own resources the financial burden of disabling sickness.

Many of these worthwhile plans in our judgment skim the cream but do not get down to those who actually need it.

The public welfare requires that medical services be provided to all without question, as needed, and programs must be pointed to recognize this and the expanding needs of a country growing in population and changing developments.

I have heard mention of surveys and surveys take time. By the time you complete and analyze the survey you are ready for another one because the facts no longer apply to the time. It seems to me that we have got to realize the scope, the expansion of our country, not only in population but in diversity of development.

The situation as we see it calls for the implementation of local, State and national health services, by all concerned, particularly Government.

Statement¹ of

MR. KENNETH EVERHART

Secretary-Treasurer, C.I.O.

Des Moines, Iowa

My name is Ken Everhart. I am secretary of the Iowa State Industrial Union Council, CIO. Our organization is composed principally of industrial workers with membership in all of Iowa's

99 counties, concentrated principally, however, in some twenty Iowa industrial cities.

Although our interest is primarily in industrial health, we are also concerned about rural health, as many of our members live in rural areas. The 1950 census shows 54 percent of Iowa people live in rural communities, and 46 percent in our cities and towns.

. . . The medical and health authorities in our State insist there is no shortage of doctors. Possibly if we use the national average of 1 doctor to 760 persons, and did not apportion all Iowa to the available doctors, we could say there is no shortage. There is, however, a considerable disproportionate spread of the available doctors.

For instance, in the city of Des Moines, with approximately 180,000 persons we have 322 doctors, including 85 osteopaths, or a ratio of 1 to 560 persons. This ratio also holds in several other sizable towns.

The total population of the state in proportion to the number of doctors now practicing gives us an average ratio of 1 doctor to 870 persons. The 1946 estimate for Iowa was 1 doctor for 823 persons; the situation is obviously growing worse.

Ads for Doctors

The real fact exists that we have in rural communities and counties 1,500 or more persons dependent upon the services of 1 doctor. That there is a real shortage of doctors in some Iowa communities is proven by a large number of ads in the Iowa Medical Journal for doctors to set up practices in Iowa cities and towns, and we understand there are at present urgent requests for doctors, from 43 communities, on file with the Iowa Medical Association.

Our University graduates each year approximately 125 doctors, and each year some 70 to 80 percent of the graduates leave Iowa for internship in other States, and few of them return to Iowa to go into practice. Of the 1952 graduating class but 1 remained at the Iowa University to serve his internship.

Nursing and Public Health

The nursing situation is even more acute. Recent studies by the Iowa Hospital Association, the Iowa Department of Health and others show there is a need at this time for 1,770 additional registered nurses and 1,800 practical nurses to adequately staff our existing hospitals, and to care for the

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

chronically ill and aged in the several nursing homes and sanitariums in the State. This does not take into consideration the need for additional nurses for hospitals now in the "planning stage."

We feel the State, as a whole, has lagged behind in the development of public health units. Fifty-seven counties in Iowa have no full-time public health nurse, but two counties have public health units worthy of the name. The most populous county in the State has a full time public health director and one other county has a director, who is in the armed services, and has not been replaced. One county has a public health center. None of the other industrial areas in the State have anything that resembles a public health center, although there are some in the "talked about" stage.

* * * * *

Not enough attention is given to the health problems of sewage disposal, drinking water, et cetera, that are arising because of the steady decentralization of industry throughout the State that is making semi-industrial areas of many of our rural communities and all of the sanitation problems that go with them.

For instance, the city of Des Moines alone has 5,000 dwellings without any connection to sewage, 3,626 outside toilets, and over 2,000 shallow wells used for drinking purposes.

The State has made real progress under the Hill-Burton Bill in the building of new, and expansion of old hospitals. We estimate that approximately 85 percent of hospital needs are now available and after the completion of the building program now under way within 2 years we should be fairly well supplied with necessary emergency hospital facilities. Very little consideration is being given in the construction of new units for the chronically ill, with but one unit of a hospital in Sioux City being converted to this purpose at the present time, less than 2 percent of the existing needs of the chronically ill are now being met.

Rehabilitation

To my knowledge nothing is being done, outside the Veterans Hospital in Des Moines and the State University, in planning for a rehabilitation program of the physically disabled because of chronic illness or accident. A small beginning of a training center has been made by the State Vocational Rehabilitation Department.

However, a much broader program must be devised. At present the Rehabilitation Department can service less than 1,000 disabled persons each year. It now has a backlog of 1,000 applications; and another 1,000 or more cases coming on each year that, because of the hopelessness of the situation, do not bother to apply for assistance.

Clinic Facilities

In the matter of clinic facilities: We have but four in the State that can make anything like a complete diagnosis, three of them in Des Moines and one at the State University. These clinics are difficult to reach by a large part of the persons in Iowa who should be benefiting from this type of service. We believe clinics should be established in all the larger Iowa cities to give this needed inexpensive service to low income groups.

Regardless of the lack of clinic facilities, however, a good program of education is carried on in certain fields of preventive medicine, namely, Tb and cancer; we have presently taken care of about 96 percent of the TB needs. Our major weakness is in the area of nervous disorders and mental health, where but one-fourth of the present needs are being met.

Hospital and Medical Insurance

There is considerable boasting on the part of the medical and health organizations that people in our State are pretty well covered by hospital and medical insurance. We hear figures of 60 percent to 70 percent of persons covered by insurance plans; but these estimates do not stand careful scrutiny.

Recent figures obtained from one of the leading life insurance actuaries show but 38.2 percent of the Iowa population is covered by all types of hospital insurance, much of it completely inadequate to protect the wage earner against a long, expensive stay in the hospital.

Twenty-seven and two-tenths percent of the population is covered by surgical and medical insurance, which again does not protect the individual or cover all the surgical and medical expenses that ordinarily arise, and we find 12.4 percent of the population covered by medical insurance alone.

In a very small percentage of those carrying insurance do they have adequate coverage to meet emergencies, and the fact remains that the large

majority of those covered by all types of insurance are in the higher paid wage earning bracket.

Of the 640,000 wage earners in the State, less than 200,000 are in the better paid skilled trades and industrial field, or in the wage bracket of \$3,000 a year and up.

In excess of 400,000 wage earners are earning less than \$3,000 per year, and a large percentage of the lower income group are not covered by any kind of hospital or medical protection.

If we can form any opinion of the findings set forth in this report on the health needs of Iowa citizens, it is that much remains to be done; that real doubt exists that the capacity of the present local and State health departments can meet the needs of the people without more assistance from individual communities as well as State and Federal sources.

Statement¹ of MR. KEN MORRIS

**President
Briggs Local 212 UAW-CIO
Detroit, Michigan**

I am president of Briggs Local 212 of the UAW-CIO. My purpose in testifying today is to acquaint your panel and yourselves with some of the day-to-day medical care problems faced by the 24,000 workers in the automobile shops we represent and their 50,000 dependents.

* * * * *

Our own experience in recent years forces us to conclude that although the voluntary plans have made a beginning toward meeting this problem, the inadequacies and gaps in these plans are so glaring—and for the individual so heartbreaking—that we must initiate a better remedy than exists today—and we must do it now.

Problems of Illness

We, at Local 212, have contract coverage which provides for Blue Cross-Blue Shield hospital-surgical benefits and weekly sickness and accident benefits of \$32 per week. The best we can say about this program is that it partially meets some of the needs of our members. It falls down completely in the following important respects:

(1) The unemployed worker. When a worker at Briggs is laid off, his insurance lapses 1 month after the month in which the layoff occurs. At that point he and his family no longer have any protection against hospital and medical costs unless he buys an individual policy at a prohibitive cost.

Unfortunately, when illness strikes the family, it does not ask the wage earner whether he is working or whether he has insurance. If anything, illness is more likely to strike the unemployed. When it does, the worker is often forced to turn to welfare aid—an alternative which, as administered today, he bitterly resents.

(2) The retired worker. The problem of the retired worker is even more acute than that of the unemployed worker. His tenure of unemployment is forever; his pension is still far from adequate; and his medical needs are greater. He cannot afford to spend \$30.75 per quarter, about an eighth of his total income, to insure himself for greatly reduced hospital and medical coverage even though such protection is a necessity to people in his age group.

(3) Problems of extended illness. The case of one Briggs worker speaks clearly for another glaring weakness of the voluntary plans. The worker, a woman 53 years of age, suffered a leg injury in a fall on a flight of steps. This happened 1½ years ago and to this day she has not recovered. After 4 months her hospitalization insurance was used up. She was then, and still is, in need of corrective medical care. For the foreseeable future she will not be able to work even though rehabilitation would be possible if it were provided. After exhausting all possible sources of income, she still has unpaid medical bills of over \$500. Her distraction over her financial problems has affected her mentally. Other illnesses are developing such as cataracts over her eyes. So she is caught up in a vicious cycle—she cannot be rehabilitated because she has no income—she has no income because she cannot work—she cannot work because she is not rehabilitated.

(4) “Out-of-Pocket” expenses. When we negotiated our present insurance, we thought that we at least had prepaid protection against

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

the costs of hospitalized illness. We have found that such is not the case. Our workers are usually charged additional amounts by doctors for surgical services—and the charges sometimes do not seem to bear any necessary relation to the services performed. Complaints from our members are so frequent that we are beginning to wonder if we are not paying considerably more for these services because we have surgical insurance. In any event, we are convinced that if surgical insurance has any validity, it must be provided on a service basis at a reasonable cost.

(5) The limited extent of present insurance. The insurance program we have today covers too small a part of the worker's total medical bill.

No Protection

It only helps to meet the cost of hospitalized illness. No protection is provided for medical treatment in the home or in the doctor's office. No protection is provided for any services in the very important areas of diagnostic and preventive care.

This last has been carried to the extreme. This was indicated by one of our members recently whose wife had been sent to the hospital for X-rays to determine what was wrong with her. The worker was informed that the cost of these services would be covered only if a surgical operation was performed within 30 days.

If prepaid medical care can help improve our health, early diagnosis is the means by which it will be accomplished. It just does not make sense to require that illness and disease reach a point where the patient must be hospitalized before the economic barrier to adequate medical care is lifted—the cost is too high in both dollars and human lives.

Individual Problems

We have pointed up some of the more critical deficiencies of the existing voluntary plans. We do not think that the voluntary agencies can solve these problems under existing conditions—either because the problem goes beyond the scope of the voluntary agency or because the voluntary agency is not trying very hard to solve it. We cannot, in good conscience, hope blindly for successful solutions.

I might say many workers in meetings and educational classes constantly raise the point about

individual problems that either they may have, that people they know in the plant may have—and many of them are usually referred to us—we as local officers usually have to deal with these people and we have to give them answers.

Let me tell you there are many times cases where you just do not have answers for people and you would like to have them. Too often people have left our offices in tears simply because nothing could be done.

Statement¹ of

MR. H. T. McCREEDY

Assistant Regional Director

Michigan CIO Council

Gentlemen, while general health, industrial health, problems of public health, and special diseases are of concern to all of us and of concern to the labor movement, we have chosen today to deal with mental health.

I would like to make some preliminary remarks or a few remarks in general in the interest of saving time, rather than reading this document.

The best illustration I can give of the need for mental health is to perhaps portray how dramatic are some of the problems.

In the State of Michigan a short while ago we had the experience of a veteran returning from war after flying 76 missions, a young man, married, under 30, with a family.

He went into one of our plants and in the course of a few weeks came out of that plant minus two hands.

It was extremely dramatic to see the physical and mental result of that sort of industrial problem—a sort of disease and responsibility from a health point of view.

Our laws provide that within a few years before that man becomes 45 years old there will be no more legal responsibility for him on the part of our present law, or industry, in which he received this accident. He will be thrown back upon the community therefore—and back upon the hidden tax burden, to so speak, of the people as a whole, for them to find ways and means of rehabilitating and supplying life to that individual.

So it goes, we think, with much of the other problems. Particularly is that true, we think, in relationship to mental health.

¹ Delivered at Regional Hearing at Detroit, Mich., September 23, 1952.

It is said that in any average hospital day 664,000 people are mentally ill while 552,000 are physically ill (1). Michigan appears to be no exception. What we have done about taking care of the majority of illnesses on the part of our people is reflected in what we have done in Michigan.

The Governor's Mental Health Commission in Michigan recommended new hospitals to provide 3,500 beds. Nine years later treatment facilities are now available for only 550 patients in the newest hospital at Northville and it will be at least another 3 years before the other 2,000 beds will be available.

Mental Health Requires New Approach

Much of the attitude apparently that we have taken as laymen, at least, to the problem, has been the attitude that mental illness was something to be treated in the fashion of long centuries ago as the treatment of witch burning—something that should not be talked about; something we should not concern ourselves with.

I think that is evidenced by the fact that we have programs for cancer, raising of funds to take care of cancer, tuberculosis, polio, all of the other diseases of the body which we are now becoming willing to recognize as social problems and treat, but here the bulk of our problem is illness, the problem of health of the Nation which is a mental problem, we still seem to treat in some fashion as though it is something we should not talk about.

Another reason why this is such an important and major problem is the problem of cost. I want to cite you just one case history in point. A man working in the city of Detroit, making approximately \$4,000 a year, had a problem of mental illness of his wife. Upon learning it was going to cost about \$15 per day for interviews with a psychiatrist this man decided maybe if he provided more convenience and comforts his wife might get along. The result was that it did not happen.

His wife became worse, and due to the feeling of burden upon her family and the inadequate situation she was living in, she attempted suicide. At this point the husband realized that hospitalization was necessary and took her to a private institution in this community where she remained for 2 weeks. This period of hospitalization brought the husband a bill for hospital and medical care of \$500 and his wife's condition was not improved.

It seems to me that dramatizes also that the problem of mental health is so costly and so expensive and our facilities and conditions for taking care of it are so inadequate as to make it one of the major problems of the Nation's health today.

Size of Problem Underestimated

We continue to underestimate the size of the problem in spite of the fact that we know that more than half of the hospital beds in the United States are required for those who are already mentally ill; that each year 1,000 children under 15 become mental patients; that one out of every 10 people in the Nation is suffering from emotional illness (2); and that the largest single cause of manpower loss during the recent war, 50 percent of all discharges from all military services, were because of personality disorders (3). We also know that there is loss of manpower and efficiency in industry from the same cause.

That Michigan, which as a State ranks 40th among the 48 States in providing acceptable facilities for the treatment of the mentally ill, continues to grossly underestimate the problem is apparent when we know that 9 years ago the Mental Health Commission recommended to the Governor and the Michigan Legislature that a new hospital of 3,500 beds be provided. Nine years later treatment facilities are available for only 550 patients in the newest hospital at Northville and it will be at least another 3 years before the other 2,000 beds will be available (4).

When the citizens of Michigan approved the expenditure of \$60,000,000 2 years ago for mental hospitals, it was believed that this sum might provide for 8,000 of the 14,000 new beds which it was estimated would be necessary in this State in the succeeding 10-year period. However, because of increased construction costs and the pattern of legislative appropriations which is at some variance with the policy that the funds made available by the bond issue should be used exclusively for the expansion of hospital space, the total facilities which can be provided are going to be considerably less than 8,000 beds (5).

State, Community and Private Resources

If this is the way Michigan is failing to win the fight for adequate care of the mentally ill who require hospitalization, what resources does the State offer to those citizens who may be kept men-

tally healthy so that hospitalization will not become necessary?

The State operates 10 child guidance clinics and this number should be expanded to 20 or 22 such clinics for the State as a whole. When one of the more recently established child guidance clinics was to be set up nine cities tried to secure it for their community, recognizing that the child with problems is often the person who becomes the mentally ill adult.

The State operates two fully staffed adult psychiatric out-patient clinics and the number of these clinics also should be expanded to at least equal the number of child guidance clinics (5).

Resources for prevention and care of mental illness in the State are augmented to a certain degree by private and community-supported hospitals and clinics but all of these agencies are beset by demands for service far beyond their capacity to meet. Long waiting lists are the rule and in many instances the cost involved makes their use prohibitive to most people. An untold number of examples of this are known to everyone who works with mentally ill people.

Shortage of Trained Personnel

The other exceedingly important aspect in regard to mental illness, which makes it the number one health problem of the Nation, is to be found in the shortage of trained personnel to staff even the facilities which do exist. There are less than one-third of the needed psychiatrists, psychologists, social workers and nurses to meet current demands from hospitals and clinics. This is true all over the United States. In Michigan the quantity of personnel now provided in hospitals for the mentally ill is far below the standards set by the American Psychiatric Association. This is true for all categories but especially in the professional classes. The two best staffed hospitals in the State meet only approximately two-thirds of the requirements for psychiatrists and physicians. Nursing positions dropped in 1951-1952 to 64 percent of the standard (5).

Not only is there an existing shortage of trained personnel but centers for training personnel are far too few. The development of more such centers requires skillful planning and funds to put the plans into operation.

So far only the two traditional approaches to mental hygiene problems have been mentioned. In this anxiety-ridden world of ours it seems be-

yond question that any reasonably sound approach to a problem of such proportions as that of mental ill health must necessarily be dealt with, not only in the confines of the mental hospital and the mental hygiene clinic but must include a coming to grips with the basic structuring of society itself.

Environmental Forces

The fundamental emotional needs of people are universal but the opportunity and means for satisfying those needs of people are affected by the environment, both psychological and physical, in which individuals are born and grow. Consequently, the insecurity-producing situations of everyday life, out of which grow the strains and anxieties that foster the development of mental illness, must be attacked. According to Dr. Sol W. Ginsburg, a well known psychoanalyst, the mental hygienists must scrutinize certain social forces, among which he includes:

The relation of prejudice and minority tensions to mental health; the problems of inadequate housing, unequal distribution of medical care, education and other social services, the changing role of the family as a center of education and discipline; problems of censorship, loyalty tests, etc.

These same forces might well have been named by a labor leader, who might add to the list such factors as marginal financial security, prohibitive costs of medical care, lack of protective provisions when illness or accident occur or when old age comes.

If we grant that mental hygiene must be concerned with all these things which affect the lives of people, how may we begin to express that concern in constructive action? We are only beginning to find the answers.

Mental Health Education

The increasing development of programs of mental health education at all levels, national, State and local, is surely one means we have adopted.

This education covers many phases of the problem but the emphasis is always on keeping people emotionally well and giving people more understanding about mental health and mental illness. Certainly it is essential that all people receive education as to what resources exist in the community to attack these problems and to aid and treat those who have been overwhelmed by them.

Much mental health education is being done in settings which serve parents who are themselves

essentially healthy and whose children present only the usual problems of growing and changing. This type of mental health education is frequently called family counseling and may be done both in groups and individually. In such education people learn how personality develops and what causes it to become warped or blocked in development. They learn something about the instinctive drives with which we are all born, and how emotional illness is related to the mismanagement of these drives, and some of the ways in which such understanding can be directed toward better mental health for themselves and others.

A major objective of mental health education should be to provide for courses giving knowledge of the dynamics of emotional development and of simple therapeutic measures which may be used in the management of people's everyday problems in all schools where professional people are trained, especially medical, nursing, teacher training and theological schools. This sort of mental health education is not directed toward training therapists but toward achievement of more understanding of human behavior out of which it is possible to be more self-aware and therefore more aware of others and how to help them to function more comfortably.

Mental health education is being carried out by the existing small group of trained psychiatrists, psychologists and social workers through their participation as teachers and consultants in public health agencies, public school systems, medical and nursing schools and other community organizations, thus enabling other professional people to make use of psychiatric understanding and to that extent supplementing the shortage in health personnel.

It is to be hoped that out of the more widespread knowledge about mental health and illness may come organized groups of citizens who will campaign for more adequate resources to keep people emotionally well and to care for those already sick; to demand and obtain more adequate funds both for training professional people in the field of mental health, and for setting up research projects which will result in increased knowledge about the Nation's number one health problem.

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In conclusion, it seems to me that we need a searching light of inquiry, analysis, education and publicity on this problem and we need additional medical, or rather additional financial, help if we are going to solve the problem.

Since mental illness is likewise not discriminatory, it attacks people in all walks of life, it attacks people wherever they live, in whatever community without regard to geography, and it is a problem that can well concern the President's Commission on the Health of the Nation.

**Statement¹ of
ANTHONY REMUGLIA
Director
Research and Education
CIO State Council
Los Angeles, California**

Approximately 75,000 of our members are covered by collective-bargaining agreements which include some form of prepaid health insurance. About 7,000 more have access to such insurance sponsored unilaterally by either the company or the union.

These figures are misleading because they include persons who cannot and do not take advantage of plans to which they must contribute all or part of the premiums. This is particularly true of the head of a family who can't afford to pay the oversized premiums needed for limited coverage of his dependents. The fact that almost half of our members are not afforded even the limited protection of present plans, despite spirited organizational interest and pressure, is cause for serious concern and sober reflection on the fate of the unorganized workers' health needs.

¹ Delivered at the Regional Hearing at San Francisco, Calif., September 29, 1952.

Although we of the CIO take a measure of satisfaction in the development of current health insurance programs which do benefit our members, we recognize that these are limited steps toward the goal of adequate comprehensive health insurance.

Limitations and Abuses

The following are limitations and abuses which, in our opinion, mark the noncomprehensive, cash indemnity plans, i. e., the commercial insurance plans, Blue Cross, and Blue Shield, all of which, of course, cover the great majority of our members. Permanente and similar group health service plans, which include about 12 percent of covered members, are excepted from the following remarks.

1. These plans are beyond the economic reach of the nonindigent worker and his family who need protection the most. This is a condition which has encouraged the harried and the uneducated to turn increasingly to the quack and the charlatan in this area.

2. Benefits do not cover enough of the health costs, particularly with respect to dependents. In addition, the choice of exclusions and limitations of benefits often leave the worker unprotected from the statistically most common expenditures.

3. The multiplicity of plans and administrative set-ups is extremely wasteful. The shortcomings in benefits have forced some unions to undertake overlapping coverage with as many as eight different companies. This introduces duplication of administration and pyramiding of commissions and insurance company profits.

It seems to us that the cost of genuine medical service is high enough and falls far too short of the demands made on it to morally justify the present proportions of commissions, profits, and wasteful administrative costs. Furthermore, the present large number of plans precludes the possibility of a broad base of members in a single plan and the attendant increase in benefits, lowered costs per member, and greater financial stability.

4. The discrepancy between cash indemnities and the medical and hospital bill which must be made up out of the insured member's pocket has been growing not only because of rising costs, but also because of the proven tendency among doctors and hospitals to color professional

ethics with the business ethics of charging all the traffic will bear.

Excessive Medical Fees

That there is substance to the complaints of excessive medical fees by many of our members was indicated by the California Physicians' Service disclosure of large scale doctorial chiseling. We refer the Commission to the Los Angeles Times of March 21, 1952, page 24, and the Los Angeles Bulletin of the County Medical Society of the week immediately preceding for the reports on this matter.

The CPS itself brought charges against some of its member physicians for such irregularities as the following: overuse of services, abuse and outright fraud such as billings for services not performed, the making of unnecessary visits, referring patients to themselves, and performing X-ray and other laboratory work not required. The outcome in these cases is now pending; however, those who are victims of the malpractices know at first hand the dangers of a service where there is no consumer participation. Which brings us to the next limitation of these plans.

5. The consumer is not represented in the fixing of rates and charges. Without participation of a third party in a plan controlled solely by the doctors, proper performance and billing for medical services becomes entirely a matter of trust. The only way to assure a common standard with fair charges, as the CPS cases demonstrate, is to spread the control over these matters to a disinterested third party, or through a board representing the public.

The CPS cases demonstrate, too, that doctor control, like any one-sided control, leads to abuses sooner or later. The only safeguard a subscriber has is through consumer participation in the management of the plan. The right of the consumer to be represented on the board of the prepaid medical care plan he subscribes to is his guarantee of fair play. It is also a necessary protection for other doctors in the plan who do not abuse the service in which they participate.

Inadequate Coverage

6. Although the worker's protection against medical expenses of catastrophic illness is far from complete, the coverage afforded non-catastrophic connected expenses is even less ade-

quate. Department of Commerce figures for 1951 show that 41 percent of the family medical bills are hospital connected, from which we conclude that more than half of the family medical bill is made up of the expense of less calamitous health needs. Certainly the less frequent catastrophic illness must be more adequately guarded against, nevertheless, the kinds of illness that, over the long run, make the greatest inroads into the family savings must not be neglected.

7. The present plans show a serious shortcoming in not providing effective preventive medical service. In money, life, health, and productive time lost this is a shortcoming which is especially salient in a population with a high proportion of aged and sickly who are attracted to California. One of the most valuable features of nonprofit group service plans such as Permanente is the emphasis that they place on preventive medicine.

Medical Facilities and Personnel

I will deal for a moment now with community conditions affecting health needs:

1. The inadequacy of medical facilities and personnel in the State of California, accentuated by the phenomenal growth in the state's population, seriously obstructs satisfaction of the health needs of our members, particularly in the areas of mental health and chronic illness.

In our CIO summer schools and our workers' education classes the question is raised over and over again by members, if we don't have enough doctors, hospitals, and nurses now, and will have even less than the demand in the future, why don't we start training the needed numbers of doctors and nurses and start building the needed hospitals now?

It becomes increasingly clear to our people that the economic barrier to adequate health facilities has become the organizational interest of the very profession which should be dedicated to promoting and safeguarding the health of the people.

2. The medical societies in the State give evidence of discouraging the growth and development of the most promising nonprofit group health plans by coercion of doctors participating in such plans. Case Number 149318 in the Supe-

rior Court of the State of California in and for the county of San Diego, provides one of several instances of this.

Superior Judge Arthur L. Mundo handed down a decision in March 1952, which found that the membership by doctors affiliated with the Complete Service Bureau, a highly successful, prepayment, nonprofit organization, was denied to them in the San Diego Medical Society, that CSB had suffered loss of membership because of coercion of its members by the San Diego Medical Society, that they suffered increases of operation as a result of coercion, and that CSB physicians suffered damage by loss of profits through professional fees and injury to their professional reputation and standing.

3. Public Health facilities built with State, local and Federal funds do not provide service at costs which the average worker can afford. Such a social failure is first produced by a Federal law, the Hill-Burton Act, which attaches no condition of availability of services in making the Federal appropriations. Then the failure is underwritten by the State law governing public hospitals built under the Hill Burton Act, by ordering the hospitals to charge "such rates as will permit them to be operated on a self-supporting basis."

Books must balance before beds and facilities built with the taxpayers' money shall be made available to the average taxpayer.

Statement ¹ of JOHN I. ROLLINGS

**Executive Secretary
AFL Central Trades and Labor Union
St. Louis, Missouri**

I desire to deal with two phases of this health program that affect working people only . . . where, one, the worker is removed from the possibility of earnings as a result of an industrial accident; and two, when illness besets him and he is unable to continue with his earning of a livelihood.

In the first instance, workers injured on the job are very well taken care of by having medical services provided them, and also indemnities in

¹ Delivered at the Regional Hearing at St. Louis, Mo., September 15, 1952.

the case of loss of limb, either permanent or partial disability—and then payment for loss of earnings during the period.

Experience and statistics have indicated to us that time lost by illness and industrial accidents by far exceeds time lost through all other causes. Loss of income and payment for medical and hospital needs in industrial accidents is fairly well met by workmen's compensation law in Missouri. The worker is partially compensated for time lost, and in the event of permanent or partial injuries. He also receives medical care and hospitalization.

In the event of unemployment as a result of lack of work, he, being able and available for work and actively seeking work, is partially compensated through unemployment insurance benefits.

The worker, whose loss of time and in some cases employment resulting from illness, must therefore rely on his own resources or upon group welfare plans established by his union. In many instances this loss of time has been increased or lengthened as a result of postponing needed medical or dental attention.

The reasons for postponement are many; mainly the worker is unable on his income to finance the needed medical or dental attention. In many instances he was unable to secure the services needed at the time because of lack of hospital facilities or physician. He therefore continues to work until forced because of the physical impairment to cease his employment, thereby becoming an emergency case.

Efforts to Wider Coverage

The one phase that we are vitally concerned with at the present time is the worker who becomes ill or suffers an accident and is not covered by workmen's compensation. In that field there are many steps being taken by voluntary organizations and by the labor unions themselves through a welfare plan.

Approximately 40 local unions in the St. Louis area have endeavored to meet these needs through commercial insurance companies providing for prepayment plans to cover hospitalization, medical bills, loss of income as a result of sickness, and group life insurance. These plans are many and varied. Some of them only cover hospitalization; some of them cover medical services under the Blue Shield Hospitalization plan, mainly under

the Blue Cross. Others include in that loss of earnings as a result of illness, and others include life insurance.

There are 52,596 members covered by the various welfare and medical care plans in the St. Louis area. However, there are 156,000 AFL members in the St. Louis area. In other words, approximately 33 percent are covered by these plans.

Health Plans

Now, two groups of AFL unions, here have established medical centers, of which you have no doubt heard, or will hear about, and I will not cover them. They have approximately 10,000 members covered, and approximately 7,500 dependents covered.

The other plans that I spoke about to you only have a very few of them which cover dependents.

Now, it is our candid opinion that these plans should operate as they are intended. They should furnish the services that are paid for, irrespective of whether it has been rendered in osteopathic or medical service, or by a doctor of medicine or a hospital.

Such is not the case with Blue Cross here today. The agency is operating as an adjunct to the medical profession. It has driven many of our people into plans outside of Blue Cross, through commercial insurance.

We believe that any voluntary plan should not have such restrictions, and if we are paying for medical service and the patient desiring such service wants to go—or through an emergency, as my exhibit here will show in some cases has occurred, where the services of a doctor of medicine were not available—that those patients paying for the hospitalization service should receive it.

Today they get \$7 a day, when the average payment is somewhere nearer \$11, or over.

Now, Mr. Chairman, I have an exhibit here outlining many of these plans, some of their shortcomings, and as we see it, voluntary plans including our union health and welfare plan which has been established as an attempt to meet the emergency are woefully inadequate.

Nothing will satisfy or cure this situation other than a national health insurance plan that is sponsored on the same principle as workmen's compensation or unemployment compensation or social security.

Statement¹ of

MR. ANTHONY TASHNICK

Business Representative

Wayne County Public Employees Union, AFL

Detroit, Michigan

I would like to discuss some shortages in hospital personnel. . . . I think that the consideration given to the training of employees in hospitals to perform work of a routine but semiskilled nature would, to a large degree, alleviate some of this shortage in health personnel that has been discussed by one or two of the previous speakers.

It has been my privilege to serve as the business representative of the Wayne County General Hospital Employees Union, AFL since 1942.

The Wayne County General Hospital is both a general and psychiatric hospital with approximately 7,000 patients and 2,000 employees.

In the last 10 years there has developed a serious shortage in the hospital of trained hospital personnel. I am sure everyone is aware of the shortage of nurses.

Nursing Shortage

In spite of all the efforts of public and private health agencies to encourage young persons to enter nurses training, the shortage continues. There has been an effort to meet this shortage by establishing training schools for practical nurses. Several such schools have been established in the State of Michigan. These schools turn out persons who can perform the less skilled duties which are now being performed by registered nurses. The output of schools for practical nurses still does not fill the need.

Unless the training program for both practical nurses and registered nurses is expanded, the patients in our public hospitals will not get the type of care they require. In expanding the training of both practical nurses and registered nurses, a change in the attitude of nursing organizations which seem to control the establishment of nurses' training schools will have to change.

Our organization has advocated the establishing of a practical nurses training school and a psychiatric attendant training school at the Wayne County General Hospital for upwards of 7 years, with very little success, and the major stumbling block has been the attitude of nursing organiza-

tions which frowned upon the establishment of such training centers in public institutions. Or at least so we are told by the administrators of the hospital.

Inadequate Training

I have seen men who have washed cars in a garage on Monday, go to work as a hospital attendant and bathe patients on Tuesday.

I have heard of men who have worked in a shop on 1 day, being asked to sterilize instruments and other equipment that is used in taking care of patients the next day; and women who have been housewives 1 week, being asked to prepare and apply sterile dressings the next.

I know of cases of men who have filled gasoline tanks on Monday, feeding patients on Tuesday. Employees are being hired and assigned to the care of physically and mentally ill patients with very little training or orientation. It is true that with the passing of time and gaining of experience, they acquire skills as a result of their work and do as good a job as conditions permit.

But I do believe that this situation could be improved if employees who were hired to take care of both physically and mentally ill persons were trained on the job. On the staff of the Wayne County General Hospital there are competent medical men and competent nursing personnel who are capable and willing to train attendants to become trained psychiatric aides and practical nurses.

Attendants Desire Training

The employees working there as attendants have indicated a steadfast desire to receive the necessary training to make them competent in their work, to increase the degree of satisfaction that they would receive from their work and to increase their earning ability by doing a more skillful job.

There seems, however, to be an inertia on the part of some of the administrative persons whose lack of understanding of the current shortage of skilled personnel in the health field makes it impossible for them to advocate the establishment of an in-service training program and to coordinate it into an effective operating training center.

Until the wage rate of the extremely difficult work in the nursing field accurately reflects the training required and the duties performed, and sufficient schools are established to meet the needs in the health field, it would seem to me that public hospitals should immediately inaugurate an in-

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

service training program to turn out personnel sufficiently skilled to perform the many routine but necessary tasks in the care of the physically and mentally ill. These people will relieve the registered nurses and doctors to devote their entire time to the performance of those duties which only they are trained to do. To advance such a program might very properly be considered by the President's Commission on the Health Needs of the Nation.

Training to Merit Certificate

From the standpoint of the presently established practical nurses' schools, it would relieve them somewhat of the necessity for further expansion. In many cases, untrained employees are being asked to perform work which only trained people can perform without danger to the patient.

I know of attendants today who, through their experience, have learned to perform certain duties which twenty years ago were only performed by an intern. I am talking of the type of training which will be established with standards sufficiently high as to merit a certificate from the State Board of Vocational Education which is granted to practical nurses and that a certificate for the training of psychiatric aides which would enable a trained psychiatric attendant to change his place of work and carry with him a certificate that would enable him to obtain employment in another mental hospital on the same level.

Statement ¹ of

A. E. BROW

Organizer

American Federation of Labor

North Carolina stands in need of expanded, more effective, and more easily obtained medical care than ever before, despite all the good work that has been done by our doctors and our State Public Health organizations. Children born during World War I, and in years following that conflict, grew into manhood and womanhood during the great depression of the thirties only to enter World War II in the early forties. In the selective service drafts of the early forties at least one-half of the young men rejected for military service were rejected because of physical defects. The reports will show that North Carolina had the largest percentage number of rejected draftees on

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

account of physical unfitness of any State in the Union.

Rural and urban populations in our State have alike suffered because of lack of proper medical attention. Both white and Negro citizens have gone without proper medical attention in all parts of this State. Most of those thus deprived of, or lacking medical care, are nonindustrial workers. Even industrial workers, where some kind of hospitalization plan has been in effect, have found that a multitude of diseases are not covered by their health insurance plans.

Thousands upon thousands of service trades workers, white collar workers, employees in small establishments and in small offices where only one or two, or half a dozen workers are employed, have no health insurance protection.

It is on account of these tens and hundreds of thousands of men and women who are as yet unprotected by any kind of health insurance that organized labor is convinced that the Public Health Insurance Plan outlined by President Truman and presented to the Congress by him is the only effective way that all of our citizens may enjoy the benefits of medical care and attention.

Medical fees have gone up and up during the past 10 years, and at the same time physicians have all but ceased making home calls, thus adding to the burden of illness. Drug prices have advanced in rapid manner, while hospital charges have doubled and trebled in the past decade. In spite of these facts, all physicians are busy and all hospitals are crowded.

Physicians give freely of their time and talent in conducting free clinics in numerous cities and county seats of the State. Health groups work with limited means to reach people who need attention. Yet, in spite of all of these efforts, and in spite of all the voluntary health insurance plans in effect in many industries and places of employment, only a small percent of suffering people have opportunity for proper medical attention.

Statement ¹ of

HARRY BLOCK

Secretary

Pennsylvania Industrial Union Council, CIO

I represent the Pennsylvania State CIO Council. We have a membership of approximately 750,000 workers in the State of Pennsylvania.

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

The difficulties of securing adequate medical care are still extremely serious for the working men and women in this area. We, in the labor movement, have made considerable progress in obtaining medical and hospital insurance coverage for workers through collective bargaining, but in spite of this progress, we are still a long, long way from our goal of providing effective medical care to all those who may need it.

The most important single fact about medical care in this county is that in the great majority of cases, it necessitates a personal, out-of-pocket expense for the recipient. This is important for two reasons.

First, because it automatically excludes from even the most basic types of medical care that proportion of our population whose budgets cannot stand the expenses which are inevitably involved.

Second, and even more fundamental to the problem, is the fact that the general level of medical services available to the people depends too largely upon the amount of money the people spend for those services. The result is a vicious circle of depressed medical care in this country.

The citizen cannot, or will not, spend enough for his medical needs, and because of that, medical facilities do not receive the income needed to maintain services at a level which could reduce costs for the medical "consumer."

It is recognized that medical care in this country does not depend upon out-of-pocket expenditures of the people alone. Charitable activities, civic appropriations, and voluntary medical insurance plans have all operated in the direction of divorcing the immediate cost of medical attention from the person who receives it. They have removed the terrible fear of cost in medical needs from many of our citizens, and tended to bring adequate care a little closer to the reach of all.

Level of Medical Care

However, the test which we must apply to our medical system involves the level of care which is actually being received by our people, and the facts prove that the people of this area, as well as of the country as a whole, are receiving little more than a minimum of medical care.

Right here in Philadelphia, for instance, people are being turned away from our hospitals all the time, and one can only guess the number of others who do not even apply for admission because they have learned it is futile to do so. The psychiatric section of the Philadelphia General Hospital is turning away many seriously, if not dangerously, ill persons each week.

A mother with a new-born baby was recently refused readmission to the very hospital in which her child had been born less than two weeks before. Frantically the mother attempted to have her baby received at another hospital and was again refused.

Finally, with the help of a doctor, the mother secured admission to a third hospital, but the delay had been too great, the baby died.

Another case involved an older woman who had lost her reason. The family tried to gain admittance to several hospitals but was refused in each. The woman's condition grew worse and she finally had to be locked in an upstairs room where she spent her time shrieking and banging on the walls in a manner that could be heard throughout the neighborhood.

In desperation the family turned to the police, who said they could help only if the woman could be thrown out into the street where she could be picked up for disturbing the peace. Thus it was that the woman spent several days locked in that upstairs room. The family was finally able to secure her admittance to a mental hospital, but only after they contacted their representative in the Pennsylvania State Legislature.

These cases can be documented. The tragedy is that thousands like them could be documented all too easily here in Philadelphia.

Hospital Shortages

Some indications of the shortage in hospital facilities here can be gained from statements made by Philadelphians who are prominent in the field of medical care.

Dr. James P. Dixon, Jr., Commissioner of Philadelphia's Department of Health, reported recently that the city had been unable to open a 670-bed unit at the Philadelphia General Hospital partly because of a lack of staff.

"We are extraordinarily short of public health nurses," he said, "and the shortage is growing worse."

Dr. Rufus Rorem, Executive Director of the Hospital Council of Philadelphia has stated that virtually all of the Council's 63 hospitals need more nurses.

Dr. Franklin Fetter, assistant medical director of the Philadelphia Hospital, reported that the hospital has "a very definite shortage" of nurses with 30 vacancies for which it has funds to pay and an actual shortage of about 250.

The really significant thing about Dr Fetter's statement is that only enough funds are available to cover 30 of the 250 vacancies. In other words, financial resources are adequate to meet only one-eighth of our needs in this particular aspect of medical care.

Effects of Inadequate Means

The fact that obtaining medical care poses such a financial problem at both the individual and community levels is of great significance to the working men and women of our land. Throughout the country, the level of medical care available varies directly with the per capita income of the area. In our poorer States there is only 1 doctor for every 1,500 persons, while in the wealthier States the ratio runs about 1 to 500.

In the face of figures such as these, it is not surprising that three times as many mothers and twice as many babies die in our poorer States as in the wealthier ones. We cannot escape the fact that these deaths, and many others as well, occur primarily because of the economic basis upon which our medical system is built.

And what is true for the population in general is also true for the population of a particular area. That is, medical care is available to the extent that one can afford it. For every citizen of Philadelphia who can afford adequate care, there are hundreds if not thousands who cannot. The great majority of those who cannot afford that care is made up of working men and women, and it is thus that we of the labor movement are so vitally concerned with that problem.

Much has been said recently about the growth of medical insurance plans which has been obtained through the medium of collective bargain-

ing. It is true that these plans have reduced the financial threat of medical emergencies for many of our people, but we wish to make it clear that we do not regard them as the solution of the medical problems of this country. We have been forced to bargain for medical insurance because it represents the approach by which we could obtain the greatest improvement in the shortest length of time, but we maintain that this type of insurance is simply inadequate to cope with the over-all medical problems of our population.

Limited Coverage

The number of our citizens who can be covered by voluntary medical insurance plans is limited, and the number of workers who can be covered by such plans through collective bargaining is even more restricted.

First of all, it is only the worker who is represented by a union who has much of a chance of being covered by a group worker medical insurance plan. It is true that some firms do provide such coverage for their employees of their own accord, but these are by and large the better established and more well-to-do companies. Most of the workers in this country are employed by the smaller type of enterprise which operates on a relatively narrow margin of profit. These smaller firms cannot afford to "give" their workers medical coverage without placing themselves at a competitive disadvantage. And workers who are not covered under a group plan generally do not subscribe to medical insurance plans on an individual basis.

Of the number of workers in this country who are represented by trade-unions, only a limited number will secure coverage in medical insurance at the bargaining table. Here again, the possibility of instituting an insurance plan depends upon the economic vitality of the employer. A great many employers are simply not able to carry the extra cost of even a minimum insurance plan.

Who Gets Good Coverage

In spite of the progress which has been made with voluntary medical insurance plans, the fact remains that even they tend to provide care to those who need it least. It is not that those who are covered are not in need of the care which such a plan may provide, but rather that this coverage comes first to the higher income worker and last—

if at all—to workers in the lower brackets for whom medical expenses can be such a disaster.

Employees of the wealthier firms which pay the better wages are the ones most likely to provide a medical insurance plan. Employees who work in the marginal shops which pay substandard wages have virtually no hope of ever securing medical insurance coverage as a part of any employer benefit program.

Another serious limitation of the type of medical insurance plan established through collective bargaining is that it seldom provides for family or dependent coverage.

Here again, the economics of the collective bargaining situation work to the disadvantage of those workers who are most in need of medical protection. The low-wage workers have the least hope of securing extended coverage for their families, even though they may be lucky enough to have coverage for themselves.

Out of approximately 62 million workers in the country you can see the amount of workers and families who are not covered by medical insurance programs.

In summary, only about one-fourth of the workers in this country are organized, and only a limited number of these organized workers will be able to secure medical insurance coverage through collective bargaining. Only a part of this number will be able to secure medical insurance protection for their families, and virtually none of them will be able to negotiate for protection in the field of preventive care—a field which has been sadly neglected in our Nation's medical system.

It is because of these compounded limitations that we in the labor movement believe that voluntary health insurance plans are simply inadequate to provide a solution to the problem of bringing medical care to all of our citizens.

The Factor of Costs

The problem of bringing that care to our citizens is one of costs—the tremendous costs which will be required to bring our medical establishment up to the capacity at which it can provide good care for all. We of the CIO are under no illusions about “eliminating the cost” of that care.

We realize that a great deal more must be spent if decent medical standards are to be achieved.

We are distressed by the present cost system in our medical care which results in expenses too high for the citizen to meet, and yet not high enough to provide and maintain an adequate medical establishment for the country at large.

Spending for Medical Care

It is clear that as a Nation we must spend more for medical care. The problem then is one of distributing the cost in such a way that it does not constitute a hardship for a person at a time of medical emergency, or a barrier to obtaining the routine preventive care which so many of our people need today. The cost of medical care can be distributed both in time and throughout the population. We of the CIO believe that only a system of national health insurance can achieve this end.

It is somewhat ghastly that so many of our people still accept the concept that medical care should be a matter of cash on the line. A system of national health insurance would distribute the costs of medical care evenly throughout our population.

Since everyone would be bearing his share of the cost, medical care would take its place as the right it should be, and not as an object of charity, or an item that can be bought with 3 dollars. A system of national health insurance would provide the funds which could bring medical care to all our citizens, regardless of the size of their pocket-book or the profit margin of their employer. National health insurance would also create the funds which are needed to expand our country's medical establishment to a level that would be capable of bringing good care to all, not only in time of emergency, but also in the realm of preventive medicine.

These are a few of the reasons why the CIO had endorsed a system of national health insurance for this country. The CIO urges that we adopt such a system as soon as possible. The need for greatly expanded medical services for our people is clear and critical. Indications are that the need will become even more critical in the future if we do not take action soon.

We need 37,000 more doctors, 49,000 more nurses, and 600,000 more hospital beds in this country and we need them soon. We need more funds for medical education, for research, and for

the rising costs of our highly specialized drugs. We need to expand our public health services at the community level, and bring medical care to the many counties in this country which are actually without a doctor, a nurse, or even a part-time medical agency.

Yes, the needs of our country in the field of medical care are clear and critical.

The CIO calls for the enactment of a system of national health insurance now.

Statement¹ of

MR. WILLIAM C. LIGHTNER

Secretary

Community Services Committee

Cleveland, Ohio

About the year 1945 because of the tremendous shortage of hospital facilities there was a campaign for funds to build new hospitals or to build new hospitals or to build additions to the present hospitals. The tremendous sum raised through this campaign was over \$8 million. These funds were given to the various hospitals according to a community survey of needs, and they in turn put on a local campaign in their community to raise additional funds which were needed to complete the work. This was necessary because of the increase in building costs during the time it took to raise funds and draw plans after the goal was set.

Corporations and citizens of the Cleveland area supported this program and the result is that hospital services are greatly improved and nearly all of the proposed program has been completed. Cleveland, like all major industrial centers, is expanding rapidly and a survey for further expansion and more hospital service must be considered. Also the staffing of these hospitals with professional and other needed personnel is of great concern, as there is a shortage of doctors, nurses and others needed to properly maintain these hospitals.

The cost to the patient in a hospital today, if they are in the low income brackets, makes it prohibitive to be ill, as they cannot afford hospitalization unless they have coverage by the Blue Cross or some other insurance organization. For exam-

ple, the daily rates of one of our hospitals are as follows:

10-bed ward.....	\$17.50 per day
5 or 6 bed ward.....	18.00 per day
4-bed ward.....	18.50 per day
Semi-private.....	20.00 per day
Private.....	24.00 per day

The above figures include board, room, routine drugs and dressing and general nursing services.

Another hospital has the following rates:

Ward service rate is \$19 for the first day and the cost of the room for the first week is a little over \$122. After 7 days the rate is a little over \$14 per day.

Semiprivate service starts with \$21 for the first day. After 7 days the rate drops to \$16 per day.

Private service starts with \$25 for the first day. After 7 days the rate is \$20 per day.

Who Pays the Hospital Bill

According to information covering 14 hospitals in the area the patients fall into the following groups according to who pays all or the major part of the bill:

Full payment by patient.....	17.00 percent
Blue Cross.....	60.7 percent
Other Hospital Insurance.....	5.7 percent
Part payment by patient—no outside assistance.....	3.5 percent
County	5.2 percent
Welfare Federation Ind.....	.8 percent
Welfare Federation part pay....	1.4 percent

The balance were industrial and other types.

During 1951 these 14 hospitals rendered 1,137,917 days of care to their patients. The Blue Cross coverage for the Cleveland area is about 70 percent; other hospital insurance is about 6 percent. This leaves 24 percent of the people in the area who are not covered because they have not purchased insurance or cannot afford it because their income is so low.

The Blue Cross regular policy only covers 30 full days and 90 partial days, although the steelworkers have a policy covering 70 full days and the General Motors plants are working on a policy to cover 120 full days but this does not cover the surgical bills and doctor bills which must be paid. Some people carry medical and surgical insurance.

According to the United States Bureau of Census of April 1950, preliminary data—the Cleveland Standard Metropolitan Area (Cuyahoga

¹ Delivered at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

and Lake Counties) shows the following report of income:

	Total families and unrelated individuals	Total families
Reporting-----	492, 100	396, 600
	464, 600	376, 800
Under \$500-----	38, 100	17, 900
\$500 to \$999-----	21, 800	9, 900
\$1,000 to \$1,499-----	22, 600	13, 100
\$1,500 to \$1,999-----	24, 500	14, 500
\$2,000 to \$2,499-----	34, 100	23, 200
\$2,500 to \$2,999-----	37, 500	29, 700
\$3,000 to \$3,499-----	52, 500	45, 600
\$3,500 to \$3,999-----	38, 800	34, 800
\$4,000 to \$4,499-----	34, 600	33, 300
\$4,500 to \$4,999-----	24, 600	23, 400
\$5,000 to \$5,999-----	45, 200	43, 400
\$6,000 to \$6,999-----	26, 100	25, 600
\$7,000 to \$9,999-----	31, 600	31, 400
\$10,000 and over-----	32, 700	31, 000
Income not reported-----	37, 500	19, 900
Medium income-----	3, 515	3, 996

If you will study the figures I have presented for your consideration you can readily see that the average individual cannot afford to be ill and keep his or her bills up under the present economic conditions. Those who have a family of four and whose income is less than \$4,500 or \$5,000 per year would be hard pressed if they had a hospital and doctor bill of any duration over and above the insurance coverage. Those in the low income groups who have no insurance coverage are simply in a terrible predicament.

Shortage of Facilities

The care for those who need attention because of a mental or chronic or critical condition cannot always get placed into an institution as soon as they should because of a shortage of proper facilities to care for them. The opening soon of the new Cuyahoga County Hospital should do much to relieve these problems of care. For instance, let me cite you a typical case—

Mr. A was driving in the family car with his wife and three children when another automobile failed to stop at an intersection and crashed into the A's car, seriously injuring Mrs. A and one of the children. The driver of the other car had no insurance and was earning only a small salary in order to support his own family. In a situation

like this a lawsuit was meaningless since the other driver had no assets.

Mrs. A was hospitalized for almost 8 months and her child for 5 months. Although the family had hospitalization, the policy covered only a small part of the total hospital bill. After running up a sizable hospital bill, Mr. A is finding it difficult to pay off the bill in small payments. More adequate hospitalization coverage might have been of real assistance to this family. Mr. A could not be considered indigent since he does hold a fairly responsible job, but added medical bills have made his load a real burden.

Other Health Needs

Our Government has chest X-ray service for the public for the purpose of curbing tuberculosis. Why can't we also have the service whereby the people can get a complete check-up at a nominal fee so as to curb or prevent the spread of diseases?

They may thereby shorten their lost time from employment due to illness and be restored to health in a shorter space of time which would cut their hospital and doctor expenses.

Another factor which should be given consideration is when the worker is out of employment he cannot afford to carry his Blue Cross or other insurance and if illness strikes his home how can he pay the doctor and hospital bills? Yes, it is true the county, city, or Community Chest may be able to take over the obligations, but should not some form of insurance program be started to cover these indigent cases?

We also need expansion within our community and State of our programs for the rehabilitation of the handicapped such as the hard-of-hearing, persons with speech defects and the blind. These people must be helped and some way must be found to aid them in becoming self-supporting.

The CIO has always approved and supported all health and welfare program for the benefit of the people from the national organization down to local union and its members. We try to broaden the scope of understanding and render assistance to our members in their health problems, and they in turn spread the information they have received among their neighbors and fellow workers.

This is one of the reasons why labor has taken such a strong stand in all health and welfare programs. They realize a healthy community, interested in the welfare of its people, is a first-rate community in which to live and bring up families.

A better tomorrow is ahead of us only if we give honest consideration to the health needs of our people at a cost within the reach of the working people.

Some program must be worked out and the sooner this problem is solved the better it will be for the Nation, for we certainly do not want a repetition of 1918 and 1919, when we had the flu epidemic. Although medicine, doctors and nurses

have made great strides in the welfare of mankind, it is possible for these things to happen again.

I believe in the saying "an ounce of prevention rather than a pound of cure."

If this Commission can get something done to get more doctors and nurses and hospitals in needed areas and medical care within the financial reach of the average worker we will have a healthier Nation of people.

INDUSTRY VOICES ITS VIEWS

Statement ¹ of

VICTOR F. GRIMA

Director of Industrial Relations

Texas Manufacturers' Association

Houston, Texas

My organization, TMA, is the largest employer organization in the State of Texas, having more than 3,000 members, consisting of manufacturing, industrial, and business firms with operations, investments, and facilities in Texas. TMA's objective is clear and simple, namely, "To improve and maintain a healthy atmosphere for business in Texas." Since there can be no healthy atmosphere for business without a healthy atmosphere for its employees, the subject assigned to me might appropriately be entitled "Industry Views its Employee Health Needs."

Examinations

Routine periodic reexaminations are accepted generally as the best means of preventive medicine in use today. Remarkable results are seen in some cases, when, after complete physical examination, the employee is assured of the absence of any organic disease and is informed with the significance of any symptoms, whether real or imaginary, that he might have. He is a different man if he knows these symptoms don't mean too much, and what they are. Employees found to have medical problems are followed up at regular intervals—weekly, monthly, quarterly, or yearly, as the case might indicate.

In some industries special examinations are necessary and are made on employees exposed to occupational disease hazards. This type of examination is first made when the employee is assigned

to the job and periodically thereafter, depending on the degree of exposure. Industry also works closely with local antituberculosis organizations in furnishing periodic chest X-ray services which are now enthusiastically accepted by employee groups.

On the health program now; cooperation of the employee is essential in a constructive industrial health program. This can be obtained by frank discussions of health problems with employees at company group meetings. Functions of the industrial health education program can be best carried out within the industry by individuals who know intimately the production processes as well as the employees themselves who are involved. The distribution of informative pamphlets, news items in company publications, and personal contact with the employee at the time of his periodic health examination, are three valuable media of proper health education.

Research on Safe Use of Product

A new phase of industrial health is being recognized and practiced today and has resulted in extensive protection to the public. This phase is the proper research in advance of the marketing of a new product to protect the public against possible hazards in the product's use. Only industry itself can supply its customers with essential information as to the composition of its products and give the public proper directions as to their safe use for the purpose for which they were manufactured.

Of course, proper standards should be established for the following: water supply; sanitary washrooms; bathroom facilities in the plant; and proper lighting, heating, and ventilation.

There must be very close cooperation between the medical, personnel and safety departments

¹ Delivered at the Regional Hearing in Dallas, Tex., August 18, 1952.

since many problems encountered in an industrial establishment are joint responsibilities. This is particularly true regarding the proper placement of workers with physical disability as well as those with psychological problems. These three departments must work closely in establishing safety rules as well as in the placing of responsibility for the causes of accidents. Poor mental and/or physical hygiene is one of the major causes of high accident frequency. Persons with anxieties or worries, whether on the job or at home; poor health habits, loss of sleep, or fatigue; poor nutrition, or inherited constitutional weaknesses, are frequently the victims of accidental injuries due to human failure.

Necessary Measures

Companies should see that all industrial accident cases receive the most competent medical attention available. These cases are followed up after their return to work until they have fully recovered.

Complete and accurate confidential medical records are essential. These should be a separate record and not a part of the employee's regular personnel record. The information contained should be confidential and available only to the physician and the employee and should not be for any purpose other than to aid the employee in connection with his company affiliation.

Certain industries whose operations are particularly susceptible to possible air pollution must work closely in cooperation with specialists from local health agencies and assist them in the development of improved control measures. Such specialists should be retained by local health agencies so that they would be qualified to investigate complaints, bring them to the attention of the management concerned, and work with the industry toward the solution.

Responsibility of Industry

A sound industrial health program functions as a part of the essential medical services of the whole community. Close cooperation must be maintained with the medical profession in the community and with the county and state health agencies.

Now, the relationship to the community health needs—industrial health programs are a separate and distinct thing from over-all community health problems; however, industry is conscious of its

responsibility to work with all interested local associations in solving the over-all community health problems. This has been dramatically demonstrated by the results of the 3-year audit and program-planning conducted by 18 committees of the Community Council of the city of Houston and Harris County. The results of this survey are entitled "Blueprint for Health." I submit it as a shining example of what should be and can be done at the local level by the cooperation of all local groups.

Briefly, I'd like to summarize and state:

(1) Industrial health problems can be effectively solved only at the industry, company, or plant level itself. No outside agency is qualified to solve the industrial health problems of any particular company or operation.

(2) An industrial health program must be economically sound by resulting in both tangible and intangible benefits to both the company and its employees.

(3) It must be based on sound industrial health practices.

(4) It must be designed to fit the particular company or plant operation.

(5) Top management must assume responsibility for the program's proper direction and administration.

(6) It must function as a part of the essential medical services of the whole community.

Industry is conscious of the health needs of its employees and is taking positive steps to fulfill those needs at the local plant, company or industry level. This approach at the local level has proved to be effective in the past and offers all hope for improvement in industrial health services for the future.

* * * * *

The CHAIRMAN. Mr. Grima, do you feel industry is responsible for the general health of the employees?

Mr. GRIMA. No, sir. I think industry is definitely responsible for attainment of the maximum of health among its employees, but we are speaking about their employees, not their families, their friends. Now, there is the over-all community problem.

The CHAIRMAN. But you feel industry is responsible for the general health of the employees, not necessarily those phases of health that might be related to their particular occupation?

Mr. GRIMA. Repeat that, please.

The CHAIRMAN. That industry is responsible for the general health of their employees, not necessarily in respect to any particular occupational hazard or problem?

Mr. GRIMA. Well, it is responsible to try and counteract that particular hazard, naturally.

The CHAIRMAN. But you feel it should go ahead and cover the general health of employees?

Mr. GRIMA. The general health aspect is its job.

The CHAIRMAN. Has your organization any plan for the small plant?

Mr. GRIMA. Surely. This thing I tried to bring out today; this principle in it would apply to any plant, whether of 25, or 2,500 or 25,000.

The CHAIRMAN. The principles would apply, but when it comes to implementing them in a smaller plant, it is a more difficult problem?

Mr. GRIMA. Well, there still should be someone designated with the responsibility to do this thing, and it can range from the matter of a part-time outside physician, as far as your examinations are concerned, but as far as the balance of the program within the plant, somebody has got to assume responsibility, and I think a great number of them do, as part of their safety and health program.

The CHAIRMAN. Do you feel that any shortage exists of personnel trained for industrial health purposes?

Mr. GRIMA. I think, perhaps, there is an over-all shortage. I think within the small plant it requires some special training if you are going to have a man that assumes such a responsibility along with other responsibilities. But if the basic principles were applied, the only limits are in the size of the need for full-time or large staff organization.

Statement¹ of

ALFRED H. WHITTAKER, M. D.

**The Michigan Association of Industrial
Physicians and Surgeons
Detroit, Michigan**

Many plans and theoretical discussions have been carried out on the national level concerning the health and safety of the working man in industry and in other business establishments. Actually, however, it has been difficult to bring this activity

and effort toward improvement down to the grass roots of the industry; that is, on the level of the working man himself.

On this same level are the medical departments which are in daily and widespread contact with the men who are working in the plants of our State. It is on this level of the doctor and nurse and employee contact that the greatest improvement can be made in the health and safety program.

The increasing knowledge of the need of medical service in industry, in large as in small industry, is creating an increasing demand for the personnel which makes up this medical service.

At the same time, as a result of the defense preparations, there has been a tremendous expansion of industrial plant development throughout the country, and where men are employed either in the construction of these facilities or in the later operation, it is impossible for the work to be carried on without suitable medical protection. Therefore, there has been a great increase in demand for personnel, and due to lack of training facilities and incentive to the men working in this field, it has become practically impossible to obtain the personnel which is required to provide this service to industry, throughout a 24-hour day.

The fact that accidents and illness occur during the night as well as during the day throws an additional responsibility on the very limited number of doctors and nurses which is available to meet this urgent demand.

Health Personnel Needed

Therefore, the association should like to use the few minutes at its disposal to emphasize that probably the most important problem in industrial medicine, and one of the most important problems before medicine as a whole, is to provide the medical personnel which the rapidly expanding industrial demand has created.

The association should also like to emphasize the importance of safety and health service in the small industries of this country.

Here in Michigan, the medical directors of several of our industries, the Department of Labor, the Detroit Board of Health, and the American Red Cross have cooperated in setting up a plan of training in first aid and safety which is now expanding from Detroit into the State, and it is hoped that this will result in a plan which will be helpful throughout the Nation.

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

The plan, in brief, is that instructors in first aid are provided at strategic points about the city, employers are encouraged to permit two of the men from the small plants to attend these 12-hour courses and receive pay while attending the course, and at the completion of the first-aid course which stressed the industrial aspect of safety work, the employees are provided with a certificate of completion of the course.

It is interesting that in the many cases where the courses are conducted, the owner of the small plant himself has been one of the small group obtaining the first aid instruction. This insures the constant attendance in case of accident of someone trained in emergency care.

Great stress is also placed upon the small plant's knowing the doctor to be called in case of accident, the hospital which should be used, and the method by which an ambulance can be promptly obtained. This information is posted in a prominent place in the plant so that even in conditions of great emotional stress, the proper procedure can be carried out.

Industrial Medicine and Hygiene

In conclusion, the association would like to emphasize most strongly the great need for the increase in medical personnel in industry. Both the educational facilities of this country, as well as the national government, should make every effort to train increased numbers of doctors and nurses and other personnel to take their place in industry, and to encourage industry to make the incentive great enough to encourage the younger physicians and surgeons of this country to go into industrial medicine in larger numbers.

Industrial medicine today is one of the most important services influencing the health of the American people. This is true because approximately 53 million employees are being served by some phase of industrial medicine.

Physical supervision of employees in industry is fundamentally preventive medicine. It incorporates the preplacement examination as well as the periodic examination. These are of mutual benefit to employer and employee.

They aid in proper job placement, which means more efficient utilization of manpower; and they assist the employee in maintaining a high level of health.

Along with the medical supervision goes that division of work known as industrial hygiene

which is the supervision of the work environment as it may affect the health of the worker.

Industrial hygiene programs are of assistance to the industrial physician in the control of occupational disease. These programs are being promoted on the basis of the privately controlled program by the employer, or by one of the official health agencies.

The whole program of medical service in industry is a combined development in a cooperative effort of industrial physicians, company executives, public health officers, and representatives of the workers, such as labor unions.

Seniority Restricts Placement of Handicapped

The association should like to stress the importance of some changes in the contracts between labor and management which interfere with the placement of the handicapped employees. The seniority arrangements frequently leave no opening at a selective type of work for the man who is partially handicapped but who is able to do many forms of work, or the injured employee whose only way of becoming rehabilitated is to be able to start first at a selective type of work.

It is recommended that in the contracts drawn up full recognition be given the needs of the partially handicapped to assist them in reestablishing their wage earning ability in industry.

There is a point I would like to make, and to us who are in this field of work, it is an extremely important one.

In the contracts that are drawn up between labor and management, seniority has become an increasingly important factor. Many men who are injured—and I might say the great majority of them—find it difficult to go back to their full-time job because of the partially handicapped condition. It is practically impossible at the present time to get these partially handicapped men back to work because the only work available is perhaps their own hard job, a job that requires heavy labor. It is impossible to replace or displace temporarily, or bump the man ahead of him with higher seniority who has a lighter job.

In the few industries which have agreed to return a man to lighter work, employment has been divided up into segregated groups so that maybe all the light work in the plant is in one of the partitioned groups and the man can go back to his own partitioned group. But that is all hard work,

and it is impossible for him to break into the partition where there is lighter work available.

So, many men who have been injured in industry require a return to lighter work. The only way they will be rehabilitated is if they can be returned to lighter work; otherwise they will be disabled the rest of their lives.

This situation poses an extremely important problem to the doctor trying to get these men back to work, and I would like to make this recommendation as strongly as I can make it here today: That in some way, in the agreements drawn up between labor and industry, there be arranged in the contracts permission for every man who is in some way handicapped to be placed in a job which is suitable for his rehabilitation.

That is the suggestion that we make.

Accident Prevention

Commissioner LEE. This matter of accident prevention, where should it be, in what agency? We got figures the other day that showed it cost the country about \$13 billion a year—the whole accident problem. We are at a loss to know exactly what agency should have the responsibility for all this accident prevention activity.

Dr. WHITTAKER. I might say for three years I served on the coordinating President's Committee on Industrial Safety and that same problem was discussed. Too many of the discussions about the responsibility are on the high national level, and it has been our effort to bring this down to the grass roots of industry, where the working man becomes injured, and where the man who is working with him when he is injured is the medical department and the safety engineer.

In industry today there is a tendency for the safety engineer to be in one group, the medical department in another. And the safety man resents somewhat any supervision on the part of the medical department.

I can say that the doctors in industry in this country feel very definitely that the responsibility for the solution of industrial safety should be in the hands of the medical men who know the type of condition which results from the injury; they are trained in the care of it and they study the causes of it, and I believe there will be a great improvement in industrial safety in this country if that is placed as a direct responsibility in the hands of the medical department in industry.

Commissioner LEE. You think the improvement is possible if it is done right?

Recent Improvement Cited

Dr. WHITTAKER. There has been a tremendous improvement in that field over the last few years due to the mechanical appliances which have come into use, making safety possible. We are down at the present time to about the last 15 percent of the accidents which depends upon the human element in industry; and that, of course, is the toughest nut to crack because there are some people, as you know, who are accident prone. To overcome that personal element is one of the greatest problems, and one on which the greatest attention is being paid at the present time.

I feel that with the educational methods—one of which I mentioned a few moments ago—we can say that great progress has been made, even in that 15 percent of accidents which are due to the personal element.

Teamwork Underscored

Commissioner REUTHER. I would like to suggest this to Dr. Whittaker. I appreciate the problem that you pose about how seniority restricts the ability to place the person who has been somewhat handicapped and who can't do his original job and might be able to do a lighter job—how seniority interferes with a project of that sort. I would like to suggest that, to the extent industry makes this an industry-labor responsibility which you evolve mutually, you can make progress. But the point where it is just an arbitrary decision which management makes, then the boys in the shop are going to feel management is tampering with their basic seniority—and that is security, the right to work as far as they are concerned.

The other thing which I think you people in the industrial medical field might be some help on—do some missionary work on—is that while in industry generally there has been acceptance of the principle of arbitration, we have in our basic contracts (as do other unions) the idea that if some grievance comes up in the machinery of the contract and you get to a certain point, then it goes to an impartial arbitrator. Sometimes the contract provides for a permanent arbitrator and sometimes we go out and find an arbitrator when there is a controversy. But not in a single contract covering 1,300,000 workers have we been able to

get management to agree that in the event we have a grievance involving a medical decision will they submit to an impartial doctor the matter for decision.

Dr. WHITTAKER. Except in the case of the Labor Board.

Commissioner REUTHER. I am talking contract-wise, where no Government agency is involved.

Suppose we have a contract man—who makes the medical decision, you see. At the point where the company is making the decision you are going to have resistance, whereas if you have some machinery that provides for cooperative effort, I think you will find people flexible and willing to accommodate the needs that you raise.

If we have a worker; for example, who a company doctor says has a heart condition and therefore cannot work, he goes to his doctor and his doctor says, well, he is really able to work. Now we understand that the family doctor of the fellow will try to accommodate him; we try to understand the human equation involved in that relationship. So we have that. The company doctor says the man is not qualified to work, has a bad heart condition. The family doctor says "You are O. K., you are sound"—I was going to say "sound as a dollar" but a dollar is not sound very much any more—much sounder than the dollar. Then we have the problem. We do not know anything about it. We have got two opinions; one doctor says he is O. K. and the other doctor says no.

Under those circumstances we have been trying to get the company to agree to have both doctors pick a third doctor and we will be bound by his medical decision, you see.

Now, it is management's reluctance to do that which is also an important obstacle in the way of working out this other kind of program where we can try to fit into relatively easy jobs those physically handicapped people who have injuries and, therefore, cannot do a heavy day's work. It has got to be done cooperatively because the minute it is a one-way street, you get people resisting.

Dr. WHITTAKER. I would like to say in answer to that, Mr. Reuther, that in the manuscript I have here we have pointed out that very factor, that these problems are only going to be solved by teamwork between management and labor and the medical departments. And I do believe that the doctors in industry today who would suggest to management that we should have a third-party

enter in and made a recommendation, and we would abide by that—at least most of the management I know would do that.

Statement¹ of

MR. O. L. ALLMAN

Industrial Relations Executive

Associated Industries of Missouri

St. Louis, Missouri

My name is O. L. Allman, 39 Patricia Avenue, Ferguson, Mo. I am employed as Director of Industrial Relations for the Associated Industries of Missouri, Railway Exchange Building, St. Louis 1, Mo. This organization is a non-profit association of business and industrial firms located throughout the State of Missouri. Its largest concentration of membership is in the St. Louis area which is the biggest industrial section of the State. The manufacturing firms which are members of Associated Industries account for more than 70 percent of the manufacturing payroll in the State.

Our association sponsors regular meetings on industrial relations subjects in Kansas City, St. Joseph, Joplin, Hannibal and St. Louis. From time to time the topics discussed at such meetings have dealt with employer policies and practices affecting the health and welfare of employees and members of their families. One such meeting was held as recently as a week ago in St. Louis. In most cases these practices have widespread effects upon the whole local community. Although we have no statistics on this subject, these meetings have enabled us to observe a definite and progressive trend among Missouri employers, particularly during the past decade.

Salutary Effects

Because of our broad general experience with employers, I desire to address myself briefly to the general subject of industrial health. Following are just a few of the increasingly prevalent practices that are having a salutary effect upon the health and welfare of employees, members of their families, and consequently whole communities.

First is the preemployment physical examination.

¹ Delivered at the Regional Hearing in St. Louis, Mo., September 15, 1952.

The old fashioned concept of the preemployment examination simply for the purpose of rejecting applicants for jobs, is practically extinct. Employers now utilize information from this examination to place employees on jobs that are most conclusive to their health and happiness with resulting increased efficiency—another example of the mutuality of interest between employer and employee. Advice to employees as to conditions discovered during such examinations enables the employee to seek immediate corrective medical service.

Some employers provide chest X-ray for all employees and many include a blood test as a part of the preemployment physical examination, utilizing the services of city and State health departments. No doubt many cases of tuberculosis and venereal diseases have been detected and cured in the early stages by such progressive policies. These practices are found principally among large employers—another refutation of the philosophy that big business is bad business.

Second is periodic followup examinations.

While some companies X-ray all employees, many more use this only for employees who work on occupations where there is possibility of toxic hazards. Periodic follow-up examinations are usually provided for such workers.

Third is utilization of handicapped workers.

Few persons use all of their physical faculties on any job. Many employers have coordinated the specialized physical examination with careful job analysis and evaluation to find that many of the so-called handicapped are fully capable of meeting all job requirements, and thus many are gainfully employed. Since Public Law 176 was passed by Congress in August 1945, designating the first week of October as National Employ the Physically Handicapped Week, Associated Industries of Missouri has each year issued a bulletin to all members throughout the State, encouraging employment of the so-called handicapped.

Fourth is safety programs.

With the cooperation of local Safety Councils, civic bodies and insurance companies, many firms have developed commendable safety programs for the protection of their employees. Such programs include providing safety glasses, shoes, and other protective equipment. I believe statistics will confirm that most industrial employees are safer at their work places than at home.

Fifth is prevention of illness and epidemics.

Most plant medical departments now go far beyond the former practice of treating only injuries resulting from accidents on the job. By prompt treatment of symptoms of many kinds they have rendered real service. This has proven to be good business for both the employer and employee in reducing absence from the job, and no doubt has helped to curb epidemics in some communities. Plant physicians usually refer the employee to his family doctor after first treatment.

Some especially progressive employers provide dental service for employees and a few even extend their entire medical service to members of employees' families.

Sixth is group insurance protection.

Most employers, large and small, provide group insurance for employees at reduced or no cost to them. Many of these policies include medical and sickness benefits and quite a number now extend their benefits to all members of the employee's family.

Seventh is health education.

Many plant medical departments carry on extensive health education of employees, offering advice and authentic reading material on such subjects as diets, safety in the home, safeguards in case of epidemics, and personal hygiene.

Eighth is cooperation with community organizations.

While industrial health programs are not the same as community programs, employers are doing a creditable job of cooperating with local community and State health organizations and other special groups such as the Red Cross, Cancer Society, Tuberculosis Association, etc., to meet the health needs of the citizens of this State.

Cooperative Efforts Stressed

We believe that industrial health programs are thereby contributing substantially toward improving community health. Health needs of the Nation can best be met by continued cooperative effort of citizens within a local community, beginning with the individual and extending through industrial, local community and State agencies. We see no need for the paternalistic hand of the Federal government to encroach further upon the prerogatives and responsibilities of citizens in their own community. What one hand of the Federal government gives to communities in the form of so-called "Federal aid," the other hand

takes away in taxes to cover the "aid" plus a handling charge of the bureaus which administer the hand-outs.

With our Federal debt now totalling \$263 billion (\$1,700 for every person in the entire Nation) and an additional \$10 to \$12 billion Federal deficit predicted for this year, we believe that this is the time to emphasize that no new deficit-financed Federal welfare programs must be initiated to do for the people what they can do, should do, and are doing for themselves at the community level.

I would like to submit with my report a brief report from Mr. Bolger, president of the W. C. Norris plant at Tulsa, Okla., which follows:

Mr. THEO. J. KRAUSS,
ASSOCIATED INDUSTRIES OF MISSOURI,
RAILWAY EXCHANGE BLDG.,
St. Louis 1, Mo.

DEAR MR. KRAUSS: With regard to the Commission hearing on Industrial Health and Safety at St. Louis, Mr. Butler of this organization will be present at the meeting on September 15. For your information, and possibly for the information of the Commission, I would like to outline just what our plant does in independently handling its own medical needs.

We have an over-all employment of 715 people. We have two nurse aides, with the nurses working two shifts, the same as the shop. We have two doctors on call for any shop accident and, of course, these doctors are also available at all times for any other ailments of the employees. We sponsor safety glasses and insist that these be worn wherever there is an eye hazard from machines, and in addition we advocate the use of safety shoes throughout the plant. I believe that our record at the moment is that approximately 40 percent of our entire personnel have voluntarily bought these safety shoes.

If there is any additional information that we can provide for this meeting, I would appreciate your getting in touch with Mr. Butler of this office.

Yours very truly,

W. C. NORRIS MANUFACTURER, INC.,
(Signed) E. C. BOLGER, *President*.

Statement¹ by
PAUL GRAHAM

Vice Chairman
Industrial Health and Safety Committee
National Association of Manufacturers
Los Angeles, Calif.

During the year 1951 the National Association of Manufacturers conducted a study of the health, medical and safety activities of 3,589 companies,

who employed 3,312,647 workers catalogued under 23 classifications. The larger classifications were: Food, chemical, fabricated metals, and machinery. This report covers about 22 percent of the average number of workers employed in manufacturing.

In 1950—of the 1 to 500-size group this report covers 5 out of each 100 employees; of the over 500, under 1,000 group, it covers 18 out of every 100; of the 1,000 group, 55 out of every 100 employees are covered. The above percentage figures are of the 1947 census.

The survey covers 347 companies of the Pacific states. Three quarters of these are California companies. It covers 140,886 employees. These employees can be listed as follows: 20 percent in primary metal manufacturing; 20 percent in machinery, including electric. Ordnance manufacturing accounts for less than 2.8 percent of all companies.

Forty percent of the companies which answered questionnaires have prepaid health plans. Approximately one-quarter of the health plans were completely paid for by the companies. Only 28 percent paid less than half of the cost. Nonprofit hospitalization medical plans were reported by 1,361 companies.

It is indicated by the survey that the large companies have excellent progressive, far-reaching health plans for their employees. It is also indicated that medium-sized companies employing over 500 people are rapidly developing good prepaid health plans.

Health Plans in Small Firms

The development in health plans in small companies has been slower. Recently, however, due to the fact that industries, both at the national and local levels, in cooperation with many insurance companies, have been able to develop plans where the risk is more or less uniform, on both a district and national level.

For instance, the National Ready-Mix Concrete Association has made, or will in the very near future make available to its membership—which will probably be representative of almost every county in the United States—a prepaid health plan which it has worked out with a major insurance company. This is representative of many industries which can catalog a uniform risk that should bring hundreds of thousands of employees under a health plan.

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

Recently in the Los Angeles area the rock, sand, gravel and ready-mix concrete industries have completed a plan for 23 separate companies—with one insurance company carrying the risk under one rate, and with uniform participation by all the companies. Coverage will extend to 1,224 teamsters, 193 machinists, 11 electrical workers, 44 laborers, 23 iron workers, and 832 office and executive workers. These workers may change employment to any one of the 23 companies without effect on their prepaid health and insurance plan.

Since the National Association of Manufacturers' Health and Safety Committee is constantly in touch with a large membership and thereby is able to see trends, it is my opinion that in view of this circumstance it is reasonable to expect that the development of health plans in the small companies will soon reach a stage where they can bring their participation up to the level of large and medium-sized companies.

Once this is done, the workers' dependents in industry should very largely be brought under prepaid medical health plans. For the most part, these plans will offer very broad coverage.

* * * * *

Dr. SHEPARD. Thank you very much, Mr. Graham.

This progress by the small industries is one of the most encouraging, enlightening and heartening in the last ten years. The problem has been to face the fact that 90 percent of the employers are engaged in industries employing less than 500 people.

Commissioner LEE. Mr. Graham, are you going to send that full report to us?

Mr. GRAHAM. I am sure the Health Committee will. It hasn't been sent out. I have a copy of it here, but it is restricted, and it has been worked on and I think there is other work that is going on in connection with it. It has been a terrific job. They have had to cover a terrific amount of companies, 15,000 of them, I think.

Commissioner LEE. We heard that the study was under way, and we would like to have a copy of it.

Mr. GRAHAM. Well, the study was conducted in 1951 and they worked the last 6 months in compilation, and they are still working on it.

Coverage Moving Rapidly

Commissioner MAGEE. Mr. Graham, would your report show the extent of coverage—that is, how

inclusive the plans are, how many plants have plans that include both medical and hospital?

Mr. GRAHAM. Yes, it will show that. It may not show enough detail to show exactly the coverage. The ones I have quoted are good coverage, and we weren't able to detail the coverage. It is moving rapidly, and if they had a medical plan, we have it. Our questionnaire will develop that, and it will be a reasonable plan.

Statement ¹ of

EVANS F. STEARNS

Vice President

Stearns and Foster Company of Lockland Cincinnati, Ohio

One hundred and six years ago our company was founded by my grandfather, George S. Stearns, and Seth C. Foster. They were deeply religious men and believed in practicing the Golden Rule, and carried this belief into their business practices. The business policies which they put into effect have been carried down through the second, third, and fourth generations and are in effect today.

We believe that it is a result of these policies which they established that we have during all these many years had an unusually good relationship with our coworkers in the business.

Old Age No Barrier

It has never been our policy to lay a person off because of age. If age has created certain infirmities which made someone unable to perform a certain job or created a hazard on that job, we have transferred that person to a less hazardous and easier job which he could perform. In that same way, when old and faithful employees retired we saw to it that even if their families could take care of them they were given enough financial assistance at least to provide them with pocket money, so that they would never be dependent upon their families for that. This led to our establishment 2 years ago of a pension system with the Equitable Life Insurance Co.

It may have been partly due to this attitude toward our coworkers and partly because we felt it was conducive to good employee relations, and partly because we felt it was worth-while from a

¹ Delivered at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

dollar-and-cents' standpoint to prevent sickness and other causes of absenteeism, that over the years we gradually increased our health and accident program.

Sometime before 1911, when Ohio law made participation optional in the State's Workmen Compensation Fund our company was either the first or the second in the State to take out voluntary membership in the fund.

First to Insure Employees

We were one of the first companies to take out group life insurance on all employees wholly paid for by our company. This was in 1915.

Very early in the thirties we made arrangements with a physician who would come to our plant whenever needed to handle all health and accident cases. Practice gradually changed to the point where at present he either comes to the plant at 9:30 every morning or telephones to see if he is needed. He or his associate also comes to the plant at any time when called.

In 1936, we provided everyone with health and accident insurance, for which we paid the cost.

In 1937, it became the company policy to require a physical examination of all new applicants for employment. In that same year we offered all employees, at company expense, an annual physical check-up by company doctors.

In 1939, we gave everyone hospital and surgical insurance at our expense.

In 1940, we began a biannual check for venereal disease, at our expense.

In 1942, we organized a successful campaign for our employees to join Hospital Care at their expense.

In 1944, we undertook, at our expense, the examination every 2 years of all employees by X-ray for tuberculosis.

In 1946, we employed the full-time services of a registered nurse and set up a modern four-room first aid station.

Low Absenteeism Cited

We have never made any attempt to figure what these health and accident measures have saved us in dollars and cents. However, we have been more than satisfied with the good physical and mental health of our employees and the low incidence of absenteeism. We have found that our accident rate, which was already considerably below that

for our industry, has come down over the past 16 years. In addition, we have been told by our employees, as well as by friends and acquaintances of theirs, that our office and factory have become a more pleasant place to work.

Many members of our organization have done considerable work for the Red Cross, Community Chest, and other civic groups. We believe such work, plus the health and accident measures which we have undertaken, have not only been of great value to our employees but also have been of real value to our company.

Statement¹ of

DR. GLENN S. EVERTS

Medical Director

Chairman Industrial Health Section

The Chamber of Commerce of Philadelphia

The Chamber of Commerce of Greater Philadelphia, an organization of business and industrial firms, some 3,000 in number, is represented by me as chairman of its Industrial Health Section. I am Dr. Glenn S. Everts, Medical Director, Curtis Publishing Co., Philadelphia, and contribute my volunteer services in this particular field to various activities of the Chamber.

We believe that many of the objectives for which the Commission's investigations would indicate a need are being adequately met in the Greater Philadelphia area through what may be described for the purpose of this hearing as a three-point approach.

First, I should like to direct your attention to the fact that between 1940 and 1952 the Chamber of Commerce conducted eight major surveys of personnel practices and policies among business firms in the Philadelphia area. The average number of firms participating in these surveys was 313, and the average number of employees covered was over 190,000. All major categories of business were represented as well as firms of all sizes—large and small.

Health Policies Surveyed

Among many other policies surveyed were those relating to employee health and medical programs. The results and findings in this area are very

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

significant. In 1940, for example, 49 percent of firms surveyed had group hospitalization plans in effect. In 1952 such plans were provided by 76 percent of the firms. In terms of employees covered 51 percent of total employment in firms was surveyed in 1940, whereas in 1952 we find 81 percent of all employees covered by group hospitalization plans.

In addition, the cost of these programs is increasingly borne by business. In 1944, 14 percent of firms with hospitalization plans paid all or part of the cost; but by 1952 this percentage has risen to 65 percent. In 1947 the company paid 100 percent of the cost in 23 percent of all programs; today 43 percent of the companies with such plans pay the entire cost.

Similar trends are shown in all other forms of health insurance. In 1948, 37 percent of firms surveyed had surgical insurance plus—this has risen to 58 percent in 1952. Insurance plans covering medical costs—other than surgical or hospital—have increased from 4 percent in 1940 to 41 percent in 1952. Cash sickness benefits were provided by 34 percent of firms in 1948. This year 37 percent of the firms furnish these benefits. Between 1950 and 1952, accident and dismemberment insurance plans increased from 40 to 46 percent. Group life insurance plans were reported by 56 percent of firms in 1940, and 74 percent in 1952.

In addition to these programs, companies provide sick leave plans with salary continuation, a variety of welfare fund plans, preemployment and periodic medical examinations, and the coverage of many health insurance programs is extended to dependents of employees.

Substantial Protection Forecast

The progress demonstrated by these surveys can be reasonably projected for the entire business community, and the continuation of existing trends will, in a relatively short time, provide the working population of the Philadelphia area, together with their dependents, a substantial measure of protection against the hazards of illness and disability.

Obviously, the Chamber and its supporting business firms cannot claim entire credit for these continuous and rather rapidly rising trends, but it is an undisputed fact that a corollary program for the expansion of industrial health services

and assistance to industrial plants and small business organizations has likewise been a major activity of the Chamber for a number of years—and is regarded locally as one of the primary stimuli to the advancement heretofore mentioned.

We realize that it is the prevailing opinion among small-plant executives that an in-plant medical service is either unavailable or its cost is out of proportion to what a smaller plant can afford to pay. Therefore, we have been actively concerned in speaking before groups of executives of the trades represented in the Philadelphia area in order to bring them an enlightened story of a smaller plant medical service.

Assistance Rendered

In response to a telephone call to the office of the Safety Council of the Chamber of Commerce of Greater Philadelphia, an appointment can be arranged with the executive of the plant in his own office.

One or two members of the Industrial Health Section, long conversant with medical problems in smaller industries, will sit with the executive and make an effort to answer any questions which may be asked, either about the value of the medical service in general or in particular, about having a medical service in his own plant.

And when he does decide to institute a medical service in his own plant we will help him with the detailed plans for his dispensary and in the procurement of a good nurse and a part-time doctor.

Several plants in this area have thus been helped to begin a medical service.

Since it appears that one of the problems which President Truman directed the Commission to investigate was "the adequacy of Federal, State, and local health programs, with emphasis on the desirable level of such expenditures," it is reasonable to assume that if they are found inadequate the Commission might feel impelled to recommend remedial legislation or an extension of Federal programs. In view of the foregoing, together with the documentation which will be filed with this brief as a matter of record, we believe that any such so-called "Federalization" or compulsory health insurance plans are unnecessary, unwarranted by the facts, and prohibitive in cost. And in support of this position we present the following resolution, which was approved by the Execu-

tive Committee of the Chamber of Commerce of Greater Philadelphia on January 30, 1950, and filed with the Pennsylvania Congressional Delegation and appropriate committees of Congress.

Resolution Filed

The resolution reads as follows:

Whereas, it is our belief that adequate medical care should be available to all of our citizens and that the extension of medical care services should be continued in a manner so that the quality of such services enjoyed by a majority of our citizens will not deteriorate.

Whereas, our present American enterprise system of health care has resulted in our country's showing greater improvements in the prevention and control of disease than any other country in the world.

Whereas, recent trends show that more and more of our citizens are being covered by voluntary health plans which do not interfere with the doctor-patient relationship nor place an additional burden on the taxpayers and this trend shows promises of continuing and should be encouraged.

Whereas, any health care plan must consider the effects on a majority of our citizens and that for a majority of our citizens best health care is dependent on a close personal relationship between physician and patient.

Whereas, any medical plan, in order to be successful, is dependent on the favorable approval of a majority of those in the professions who must be relied upon to render the proposed services.

Therefore, be it resolved by the Philadelphia Chamber of Commerce, that this body go on record as being opposed to any compulsory plan of health insurance which does not conform to the above condition; and be it further

Resolved, That our attitude on this subject be conveyed to our Federal and State Legislators and that the Committee on Compulsory Health and Sickness Benefits be instructed to recommend a program for the approval of this Board as to the most effective way in which the Chamber can point out to the general citizenry the disadvantages of compulsory plans.

Medical Facilities in Small Plants

Commissioner HAYES. Dr. Everts, since you have been studying compulsory health, I wonder if you would give the Commission the benefit of your

views with regard to the adequacy of health and accident facilities in small plants in this area. It has been alleged that by and large throughout the country the overwhelming majority of the small plants and businesses have inadequate facilities for first-aid treatment of industrial sickness or accident. What is the situation in this area, and what can be done about it if you have any opinions?

Dr. EVERTS. In the first place your statement is perfectly true. We regard here, as well as most other industrial cities of any size do, the small plant problem, so far as extending medical service, as the bottleneck, so to speak, of medical services in industry. We are doing what I reported on here in just this way. We have for 10 years been actively engaged in giving every small plant an opportunity to learn about the possibilities of the small-plant programs. It can be done; it has worked, and there are physicians to do it; there are nurses to do it, and they are available. It is a question of stimulation. We are in the process of stimulating the executives of the plants to learn that there is an inadequacy there and that there is a possibility of improving it at a price they can afford to pay. That is the thing that seems to us throughout the industrial medical world as one of the biggest problems we have. It can only be met by continued and intensive education at all levels.

Commissioner HAYES. Well, of course, financial considerations enter into it also, do they not, Dr. Everts?

Dr. EVERTS. Indeed they do, but a small plant program can be scaled down to meet the cost—that is, I mean at a cost that the small plant can afford to pay. For instance, it is possible to have a part-time doctor who only comes in maybe 2 hours a week, at two different times, and a part-time nurse who may only come in 2 or 3 hours a week for a very small plant. For 4 years I serviced a plant with only 25 employees by going in once a week. The nurse was there more often. That may not have been adequate in the sense we regard complete medical coverage as some of the large plants are able and can afford to do it.

Commissioner HAYES. If the employees would only wait with their accidents until the doctor and nurse got there it would be helpful.

Dr. EVERTS. Yes, it would be helpful; we agree.

Statement¹ of

ALVERTA M. WENGER, R. N.

**Chairman, Committee on Industrial Health
Detroit Industrial Nurses Association
Detroit, Michigan**

In Michigan the greater part of industry is composed of small plants; of the 350 industries represented in Michigan, 60 percent are located in the Detroit area and employ 60 percent of the nurses who work in the field of industry.

The industrial nurse is a graduate registered nurse, and is a potent factor in the development of health programs through helpful, friendly relations with the worker and management. By aiding in the Industrial Health Program in the maintenance of the worker's health, management recognizes the contributions made by the industrial nurse. Healthy workers lessen management's problems.

Under direct health services the registered nurse gives professional nursing care to the injured and to the acutely ill; counsels the worker in health maintenance; aids in plant sanitation, in plant safety programs for the prevention of accidents, in the placement of the disabled worker, and in the utilization of the older worker; gives counsel in nutrition in relation to health, mental hygiene, safe-home environment and good principles of child health; interprets compensation and other insurance policies and pension plans. When in need of home care the industrial nurse makes home calls to the worker.

In 1946, there were 816 nurses engaged in industrial nursing; on January 1, 1952, there were 983. This represents an increase of only 167 nurses doing industrial work in the past 6 years.

If financial aid is needed to overcome the shortage of nurses, may we recommend that the funds be raised locally? The hospital fund of "Greater Detroit" is an example of how it can be done.

We are advocating health—it is most important that we keep our financial situation healthy, too. The individual who has the innate ability to become a good nurse and whose foremost thought is that of serving humanity will also possess the mentality needed to recognize a moral obligation and will be willing to repay any indebtedness incurred in obtaining professional training.

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

Statement¹ of

OTTO F. CHRISTIANSEN

**Executive Vice President
Minnesota Employers Association
Minneapolis, Minnesota**

I am the executive vice president of the Minnesota Employers Association, which is the Manufacturer's Association of Minnesota, and in which 1,164 industries of the state belong. * * *

We almost make a fetish of our health and accident program here in Minnesota. I could present a hearing to you which would take all day and would take as many witnesses as you have had today on the practices that we use in preemployment physical examinations: periodical physical examinations; our work with dust and fumes hazards; our work in Minnesota on the Iron Range; the health and safety developments we have; the audiometer test on employees; the vision tests we are using; the hospitals in industrial plants; the vitamin pills; the cold shots; the diathermy and heat treatments; the industrial nurses to follow up on sick leave when we have a sick leave clause in the contracts; the problems that we have in security, where we have handicapped and injured workers; and the difficulty we sometimes have in drafting our labor agreements when we want to reserve the right not to promote certain men because they are not physically able.

We would like to talk to you about the program and about the millions of dollars being spent each year in Minnesota in plant cleanliness, in light, heating, ventilation, and sanitation control of hazardous conditions—dust, smoke; our on-the-spot first-aid organizations, such as General Mills, who have reduced their accident records to unbelievable figures; and a hospital in the George A. Hormel plant at Austin. The Hormel Company spent hundreds of thousands of dollars in our state in the last few years to do work in preventive health and accident prevention.

I would say that as far as the thinking of our people here is concerned, we think that we are making splendid progress, but we see plenty of opportunity to do many more things.

There are many things which the Government can do, both on a national and on a State and local

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

level, working with industrial management, to work for the general health and welfare of all the workers.

Statement ¹ of
**THE CLEVELAND CHAMBER
 OF COMMERCE**
 Cleveland, Ohio

Cleveland Employees Covered by Health Plans

A recent survey by the Cleveland Chamber of Commerce, so new that a report has not yet been published, provides important information on the extent to which hospitalization, surgical, medical care, sickness, and accident, and accidental death, and dismemberment benefits are available to

¹Submitted at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

Clevelanders. Data on these voluntary benefits were provided by 130 representative companies employing a total of 154,954 in the Cleveland area. With respect to their hourly rated employees, these companies, which have on their payrolls one out of every four employed Clevelanders, report the following benefits:

Benefit	Provided by per- cent of reporting companies	With all or part of cost borne by percent of com- panies providing benefits
	<i>Percent</i>	<i>Percent</i>
Hospitalization.....	100	73
Sickness and accident.....	91	91
Surgical.....	82	69
Accidental death and dis- memberment.....	70	89
Medical care.....	28	82

THE FARMER AND RURAL HEALTH

Statement ¹ by
DR. C. HORACE HAMILTON
 Professor, Department of Rural Sociology
 North Carolina State College
 Raleigh, N. C.

Several years ago when Dr. Clarence Poe was president of the Broughton Medical Care Commission, he set the stage for the final report when he said that what North Carolina needed was more doctors, more hospitals and more health insurance. Then he stressed that there were three groups that were perhaps in greater need than any other groups in our State.

As between the rural groups and the urban groups, he felt that the facts showed that the rural people were more deficient in the need for medical care than the urban people. And as between the white population and the Negro population, he felt that the facts showed that the Negro people of this State were in greater need of medical service relative to what they were getting than the white people.

Then among the farm population, as between owners and tenants, he felt that the greatest need was among the tenant population.

¹Delivered at the Regional Meeting in Raleigh, N. C., August 25, 1952.

Negro Sharecropper Gets Least Service

So if you analyze those three groups, I think that you will put at the bottom of the ladder, so far as the need for health services is concerned, the Negro sharecropper, the Negro tenant farmer, and the Negro farm laborer. And perhaps the people in the State who are receiving the greatest advantages when it comes to medical service, hospital service, and so on—even though they may not be getting all that they perhaps need—would be the higher income urban white population.

Now, before I go into looking at some of these charts, I would like to state in a few brief sentences what I think these general statistics tell about the need of the rural population, particularly, and then later on in the Negro sections and in other sections we will get comparisons between these different groups. And as much as possible we shall stick to the big subject of getting more doctors, more hospital beds, more health insurance, and related facilities to meet these needs.

On the basis of a very careful sampling study of the rural and urban populations of the sixth largest rural county in North Carolina—and that is Wake County, N. C.—I came to these very brief conclusions, which admittedly are perhaps over-generalized. But I believe that studies in other counties of equal size in the South would show approximately the same situation qualitatively, at

least, if not quantitatively, and that the direction of the differences would be the same and the magnitude of the differences between the various groups would be very much the same. As a matter of fact, I expect there are a lot of big rural counties in the deep South where conditions would be much worse than they are here in Wake County.

Status of North Carolina

These summary statements are as follows:

As compared with a reasonably good standard of medical care, farm people of North Carolina are using:

Less than one-half the needed services of physicians.

Less than one-half the needed hospital service.

Less than one-third the needed dental service.

Less than one-third the needed eye service.

Less than one-fourth the needed diagnostic service.

Less than one-fifth the needed service of medical specialists.

Less than one-tenth the needed health insurance.

Now, some of these conditions go back, of course, to other factors, such as income, standards of living, educational levels, and the like. For instance, Negro rural farm-tenant families had a level of living index of 38.4 percent as compared with the highest normal living of 100 percent. The urban white population had a level of living index of 94.6 as compared to a perfect score of 100. And I will not take time to indicate what I mean by "perfect score."

On the income side, the rural farm Negro family had an income of \$976—that is the median income—as compared to the highest level, the urban white, of about \$4,500.

Now, just a word about some charts I have brought. The first chart is an infant mortality rate chart which illustrates the differences between rural Negro, urban Negro, rural white and urban white. This chart illustrates the percentage of births in hospitals, the trend from 1942 up to 1952, and it shows, of course, the rural Negro at the bottom and the urban white at the top in the amount of medical service for obstetrics in the hospital.

Incidentally, the amount of internal medical service is highly correlated with that fact. In some of the higher income areas and communities of this State, incidentally, about 60 or 65 percent

of the people who die are hospitalized before they die. In rural North Carolina, that is only 30 percent. In other words, that illustrates that 50–50 statement that I made.

The same thing holds true with the doctor. This is based on the Wake County survey and shows the number of doctor calls made by these different groups each year. For instance, the white urban, about six calls on the doctor, either at home or at the office; rural farm, white, about four and one-half; and then the Negro, urban, very low, and the Negro rural family about the same, and the rural nonfarm slightly higher.

Moving over to the next chart, e. g. who goes to the hospital, you have pretty much the same picture with the rural nonfarm being quite high, but the urban being also high, and the rural farm white and Negro, being lower.

This is the number of hospital cases per 100 persons annually, the rural farm Negro being about three. The urban white goes up to about 14.

Rural-Urban Ratio

The next chart is entitled "Doctors and People in Rural and Urban North Carolina." The rural population has been going up since 1910. The number of rural doctors has been going down. I have the statistics, preliminary statistics, which show that there are about 500 rural doctors in North Carolina. I think another speaker on the program this morning, Dr. George Bond, is going to discuss that. Urban doctors have been going up and urban population has been going up. The urban doctor has been going up much more rapidly than the urban population.

Here is some more information on people per doctor in North Carolina. Small communities have a larger number of people per doctor than the urban communities. The urban communities have about 600 people per doctor as compared to these small rural medical service areas, which have around 3,000 people per doctor.

Actually, the situation is much worse than that shows because we have included in these doctors here a lot of people who have already died or have moved away, or for one reason or another are not in actual practice.

The age of doctors is also going up in the country, and has gone up much more rapidly than in the city.

I would like to close, but just let me make this statement, and that is that we do not mean to imply

in quoting these statistics at all that we are as far behind certain other sections of the country as you might think. The incomes in this State and in the South have been rising rapidly, and if you will study carefully the age-adjusted death rates in the South and in the rest of the Nation, and in North Carolina as compared with the South and the rest of the Nation, you will find that the white people in North Carolina have as low a death rate as the white people in the rest of the Nation, and that is true of the South in general. The nonwhite people have as low a death rate as the nonwhite people in the rest of the Nation. Of course, that includes Japanese and Chinese as well as Negroes and other nonwhite people from different places.

If anyone wishes to verify my statistics, I suggest that he either go to the same sources that I went to or make a survey more inclusive than the one that we have had here.

Statement¹ of

DR. GEORGE F. BOND

Chairman, Committee on Rural Health

Medical Society of North Carolina

Bat Cave, North Carolina

More Doctors Wanted

It has been my good fortune in the last 2 years to attend rural health conferences all over the United States, and to hear at the grass roots level what country people want in the way of health services. The one question which recurs again and again which comes out of every State, especially in the South, is: "We want more doctors."

On that score I will stand about half way between my friends Dr. Davison and Dr. Brewer. I think that undoubtedly there is a great shortage of rural physicians, but I think we need not measure that shortage in terms of urban life. With our present day control of diseases with antibiotics and with the better methods of adequate medical care that we have and with better facilities, a country doctor can now care for more people than he could in the years passed. He can probably care adequately for at least 3,000 and probably 4,000 people.

Therefore, base your estimates on that requirement. Nevertheless, the need is great. We have

a shortage in this State and throughout the South. In the past three decades we have seen the gradual loss and final death, almost, of the country doctor. You will hear later in the day many of the things which contribute to bringing a man into a rural practice.

But I tell you there is only one consideration which is paramount, and that is this. We will not educate, and you may not expect a boy with a 20th century medical education to go out into the back hills, into the rural areas, and practice saddlebag medicine without facilities. And by "facilities" I come to the point of the small hospital. When I say "small" I mean truly small.

I think we must solve this problem of getting workshops out there so that we will get country doctors all the way from the level of small community clinics, which are no more than diagnostic centers, of good, well-equipped offices, up to the level of the 20- or 25-bed hospitals.

Hospital Beds in Rural Areas

Now, you will hear a great deal of argument against these small units. I have had a fair amount of experience with them, and in a few moments will try to tell you something about it. In 1947 this State and other Southern States, rural States in general, received the greatest shot in the arm that they will ever get through the beginning workings of the Hill-Burton Act. In this State, under the auspices of the Medical Care Commission, we began to provide some beds in rural areas. The accent was on larger hospitals, admittedly. But we began to provide the beds that were needed for rural people.

Experimentally, in the last few years we have seen the construction of a few small units under the Hill-Burton plan. They have not been uniformly successful. Seven out of eight of the small hospitals built have been very successful and one has failed, for reasons which we of the rural health committee of the State of North Carolina Medical Society are going to try to determine. However, there is no answer to the question once more that if you wish to get doctors in the country, you and I, and the people of this State and of the South, somehow are going to have to find the means for providing adequate facilities in those areas.

Limitations of Small Hospitals

Again you will hear that a small hospital is a dangerous situation, that it is expensive. I think

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

that Dr. Hamilton could tell you that our present data on that problem indicate that it is not more expensive than larger hospitals. They will tell you that it cannot be staffed, that it will be substandard. I protest that it will provide bread and butter medicine. That is the basic quality of good medical care which can be provided anywhere, and it will be brought to the people under that program.

They will tell you finally, in argument, that the medical men, the personnel who will man these hospitals, will be subject to considerable temptation to faulty practice of medicine. I submit that there is a ready answer to that. In the first place, we must train and we will train men of good medical conscience who will not do that type of thing, and secondly, there is a perfect check in the form of a medical audit of any hospital in the State of North Carolina—and it can be done. That can be applied to small hospitals as well.

Now, these hospitals have been built under systems of public funds, but I would also point out that many communities are capable and willing to provide institutions, small community clinics right up to the size of 20 bed hospitals for themselves—and by their own sweat and money. Let us not discourage any communities capable of doing that.

So we come to the question of facilities and the question of finances. Let us look for the acceptance of the responsibilities there. The responsibilities for the construction of these small workshop types of hospital which we know will be necessary to secure and maintain country doctors are the responsibility of yourselves and the population of this State and of your communities, through Hill-Burton funds or through individual action, either way. The responsibility for the training, preparation and placement of physicians in these areas lies almost squarely with the medical profession and with the educational field of our profession. That can be done. It will be done. We assure you of it.

Bat Cave Hospital

Commissioner POE. Dr. Bond, everybody here wants you to take the last 2 minutes now to tell about the Bat Cave Hospital.

Dr. BOND. The work at Bat Cave was simply an example of what a community can do for itself when they are spark plugged. My community covered about 500 square miles and embraces about

6,000 people who had not had adequate medical care before.

I moved into the area to practice medicine, and practiced saddlebag medicine for 3 years, and was determined to leave if we could not secure facilities, and told my people so, and in 9 months' time, with a lot of luck and a lot of sweat and a little bit of money, we built a 12-bed hospital. It is now a 16-bed hospital. It is staffed from the area. It is financed entirely from our area. It is a community-owned project, and we believe that we are practicing a reasonably good type of "bread-and-butter" medicine.

Women are having their babies there safely. The amount of surgery which I think I am wise enough to be able to do, I am doing. The remainder of it, I am sending on. And as far as ordinary medical care and pediatrics are concerned, we think we are covering about 90 percent of the needs of the area, as well as the public health facilities which we try to offer in that area.

That is what a community can do from a grass roots level. It requires spark plugging, though, and it means that we are going to have to get our health educators out in the field and we are going to have to get our doctors out in the field. We are going to have to get some grass roots help from the communities, and I do not believe that most of the communities in North Carolina can do this by themselves. A certain percentage can. The remainder deserves and must have some help in the form of funds—State funds.

Nevertheless, the problem of medical education of the people to receive and to cherish those facilities and to guarantee the return of a country doctor is our main problem here in the South this year.

**Statement¹ of
EDWIN CHRISTIANSON
President
Minnesota Farmers Union
St. Paul, Minnesota**

In my contacts with farmers throughout our State, I find a keen interest among rural people in their standard of living, and especially in their health needs. Today the rural farm families are as much concerned about the physical fitness of their children as are city folks, and feel

¹ Delivered at the Regional Hearing in St. Paul, Minn., September 2, 1952.

the need for medical services that are not now available.

The statistics of health facilities in our State certainly bear out the need for many new health centers strategically located, with more doctors, dentists, and equipment.

Era of Centralization

Today we are in an era of centralization. Schools are being consolidated; large shopping centers are being constructed; and medical and hospital facilities are being centralized. This centralization is naturally doing away with small communities and their activities, and certainly has an avowed effect on the family farmer and the farm family. It is generally conceded that the family farm is the bulwark of democracy; therefore, this centralization program must be evaluated as to its effect on our way of life.

Centralized health centers are very important, and we need them; but we need even more the small town clinic and the so-called "community doctor." There are several things that stand out as a sorry picture on the face of medical and health facilities, for farmers in our State.

Shortages Cited

First, a large percentage of our communities do not have clinics or a doctor, so rural people do not have health facilities available, except at central points.

Second, prices charged for hospital and medical attention are such that even though parents know their children need medical care they go without because they do not have the necessary funds.

Third, few communities and hospitals have ambulance service, and those that do have find many rural roads impassable in the winter and in the spring of the year.

Fourth, the rural telephone system in Minnesota is very poor, with only a small percentage of farms having telephones, and the service through some telephone exchanges is very limited.

It is evident that the average small town clinic is much more reasonable in its charges than is the larger medical center.

Today, in several Minnesota communities, we find that if a person is to get an appointment to go through a clinic he must wait 6 to 8 weeks to get in. A dental appointment is just as difficult to get, and the waiting period is just as long.

My observation is that the present health facilities in our State are always in an emergency status, not in structure or in staff, but in production, because they are always loaded and full with emergency cases.

In an emergency people think little of the costs, as a debt load or mortgage means little when a life is at stake. The point that I am making is that our present limited health facilities make for a program of scarcity and high charges, with emergency prices establishing the base, and leave the normal examination and treatments to become emergency cases because of the lack of local medical care and facilities.

I could cite several illustrations from among our counties, but will use only a few of them.

In Grant County, with a population of 9,542, I have been informed there is no hospital, and at present there are 4 doctors in the county. One is leaving soon, having been called into service. There is no ambulance service available, and several of the villages have no telephone service between 8 p. m. and 8 a. m. daily, and no service on Sunday and holidays, with the exception of one hour in the morning and 1 hour in the evening. The nearest hospital is from 25 to 35 miles away. . . . It sums up like this: for Grant County, no hospital; four doctors for 9,542 people; no ambulance service; poor telephone system. And of the 1,247 farms, 1,085 of them are located along dirt and gravel roads.

Yellow Medicine County, like most of our counties, has many communities with no resident doctor. Hanley Falls, Cottonwood, and Boyd have a part time doctor on certain days each week. The cities of Montevideo and Marshall have medical facilities and doctors, but are overcrowded, so many of the residents of Yellow Medicine County have to come to the Twin Cities (Minneapolis and St. Paul) for medical treatment.

Few Facilities in County

In Lake of the Woods County there is one hospital for the entire county and adjoining Canada. This is located at Baudette, Minnesota, and patients come from Beltrami, Koochiching and Roseau Counties, in addition to the Canadian communities adjoining and many tourists who headquarter on Lake of the Woods.

The residents there have told me that the building is very inadequate in size, and a new wing for a children's ward should be built. As it is now,

it is necessary to crowd as many beds and cribs into each room as can possibly be placed in them.

Territory served by this one hospital and two doctors is 60 miles south, 72 miles east, 36 miles west and north into Canada, possibly 50 or 60 miles.

Minnesota farmers have a very definite problem in getting proper medical service because most medical facilities and doctors are scheduled so far in advance that it is necessary to get an appointment several weeks ahead.

This is not possible for a farmer in many instances—his work to a large extent is dependent on weather conditions. If it rains he can go to town; if the sun is shining he must work with his crops.

Providing Good Health Care

Because of the high cost of medical services, a farmer with a family of six or eight finds it difficult to add to his already heavy debt load and is likely to sacrifice the health of his family for a payment on the farm mortgage. It is true that today one can carry health insurance, but, again, present health insurance is an emergency measure. It helps one to meet a crisis when it comes, but it does not help to avert a crisis in health care.

Minnesota has been fortunate in having several new hospitals built, which indicates we are moving forward in facilities in medical care. However, a great deal is yet to be done to make health facilities available to low income groups, and to develop a pattern of services and facilities at moderate prices and at strategic locations.

I quote a paragraph from our Farmers Union program for 1952, headed "Good Health—Everybody's Basic Right":

This requires, first, that our Nation have ample physicians, dentists, and nurses. But the present system has not been able to supply them. We have never had enough rural doctors. Now the doctor-nurse shortage grows worse.

We advocate whatever program can best cure this shortage. Medical schooling and research are already heavily subsidized by Government, but medical schools need more Government money.

Everyone must be able to afford medical treatment and hospitalization. These are life and death matters, and they should not depend on the size of a person's pocket-book. Farmers as a group have always had grossly inadequate medical attention. "Anyone needing medical treatment or hospitalization should get it at once without first having to prove he can pay. This means there must be national health insurance.

We point out that disease prevention is preferable to disease treatment. We favor all practicable means of sanitation and disease prevention.

We urge measures to insure good nutrition for everyone.

Mental health is important, too. We favor a good state mental health program, further research and better facilities.

The Farmers Union believes that good health is everybody's basic right. We maintain that all people deserve equal medical rights and that everything necessary should be done to make this possible.

Statement¹ of

MRS. LULU EVANSON

State Educational Director

North Dakota Farmers Union

Jamestown, N. Dak.

I want to bring to you some of the needs that we have in North Dakota.

Of course, we do not have enough doctors in rural areas. We do have doctors who are concentrated in our major cities, and, as you know, North Dakota is a small town State, so we do not have enough major cities—that is, we have very few, so that our doctors are concentrated in these few cities, and it makes the distance too great for many of our people to seek medical care.

We are not going to be able to get doctors into the rural areas, until we give them workshops—a hospital in which they may treat their patients. We have that problem of providing these hospitals.

We have built about 16 through the Hill-Burton fund and I think as many more are being built without the help of the Hill-Burton Federal funds; but these are being provided in county seats.

However, we still have a number of counties that do not have hospitals, and it is very difficult to get doctors.

I think the hospitals that we have been building have been too large. Now, I am sure that you will not agree with me, because most of them are only around 20 or 25 beds.

Cottage Hospitals

I like the idea that they have in Manitoba, where they are building what they call cottage hospitals of 8 and 10 beds, some of them 6 beds, and also

¹ Delivered at Regional Hearing, Minneapolis, Minn., September 2, 1952.

provide for a local practitioner. These hospitals can be built without the great cost of these larger hospitals. They do not have the problem of maintenance which we are experiencing already with our 25-bed hospitals, because the cost of maintenance is extremely high there.

We want these small hospitals to provide for our doctors, so that they can take care of mothers who are to be confined, take care of tonsillectomies in the community, and then will move the patients who need specialized care to district hospitals.

We find that where we have a 25-bed hospital or a 20-bed hospital and 1 doctor, he wants to keep his hospital filled, and he will often attempt an operation that he should not attempt—one which he should send to specialists in the larger district hospitals.

We have the example of one doctor who said: "I am awfully tired of being a taxi driver. Unless my town provides a hospital, I am not going to stay in this town."

Now, he was very badly needed there, but he said: "They come to me and they need hospital care. I do not have a hospital, so I have to take them into the next county where there is a hospital, and the minute I take them there I lose my patients."

So he said, "I am a glorified taxi driver. I was not trained for that; I was trained to be a doctor."

We need an integrated health program under which the doctors in the little villages could take patients to larger hospitals where they have greater facilities to treat them, and where the doctor would not lose his patient. That is one of the big problems. I have a case here that I think would be of interest to the Commission.

North Dakota, as you know, is the greatest State in terms of power machinery in agriculture; that is, we have more power machinery than any other State in the Union. It means that we have a very high percentage of accidents in our State, and we don't have doctors to take care of these emergencies.

I have in mind a person who was in a very bad accident. It took 21½ hours before they could get a doctor there. She could have been saved, had a doctor been there to give her blood transfusions, but by the time the doctor got there it was rather hopeless, and the lady died.

Now, this was unnecessary. If we could have had a doctor or a small hospital to bring her to and

give her the proper care, this need not have happened.

Dental Problems

We also need dentists in North Dakota. That is a terrific problem. Doctor Swanterman, of Grand Forks, tells us that ninety-seven percent of our children have dental caries. The situation is very bad in North Dakota, and very little is being done for the rural areas.

I talked to a county nurse after she had been there 3 months and I said: "How are you coming along?" She said: "I am shocked. I cannot get over the fact of these children, everyone of them having terrible teeth. They have tonsils and they have adenoids, and nothing is being done. There is one dentist in the county, and he could not begin to take care of them, even if we could give them the proper care, and their parents are indifferent. I am shocked. I want to leave the county. I just don't want to work there. Everything seems so hopeless."

I said: "What are you doing about giving these parents an understanding of the fact that these children must be taken care of?"

She said, "They are completely indifferent, they are not interested. I know that many of them have never even seen a toothbrush."

I said to her: "Well, if the parents won't do anything about it, then what are you going to do?"

She said, "I don't know what to do. I am helpless, and it is a most hopeless situation."

Now, that is certainly a sad state of affairs when you cannot find an answer to these problems—and there are answers.

Public Health Coverage

We have public health coverage for about 43 percent of our people. We have five units, five public health districts * * * but in those five districts we have only one full-time public health officer, with no public health training when he took over the job. The rest of them just have local doctors who practice public health, but none of them has had any special training in this field.

Our local doctors are so busy with their own practice that they have very little time to give to public health service.

One of the nurses told me of diphtheria breaking out in a small rural district. She called and called frantically for a doctor to come out, and the doctor said that he was too busy with his own practice, and after 3 days, when there were 23 cases of

diphtheria, then he came out. If he had come out the first day, perhaps some of those severe cases could have been avoided.

But our people are not happy with the public health service that we are able to give them. Instead of having full time public health officers we have a busy administrator with no program to administer, because we do not have the personnel there to administer the program. So we are very unhappy about the present public health services in our districts, and the commissioners are threatening to withdraw funds unless they get better service.

Health Education

We need health education; we need a great number of things that we do not now have.

In the matter of dentistry, the situation is pathetic. We tried to teach them nutrition and good food in their schools, and these very same schools have "coke" machines and candy bar machines where the children at noon make a meal out of a coke and a candy bar, and then we expect them to have good teeth.

Unless the schools are going to cooperate in health education, there is very little that we can do about health education. We know, as lay people, that the children are going to have what is available to them in the schools.

Now, we could have all the hospitals and doctors we need, and we could have all the dental care and all of the facilities necessary for good health, but let me tell you that unless the people have the wherewithal to pay for this health it is not available to them.

So we have to find a way of providing complete medical care for the people.

The health insurance programs up to date are not providing for rural people. Less than 3 percent of the people have health insurance. Unless we have complete coverage we are going to continue to bring up our children, one-third of whom will be handicapped.

The Health Record

That is the record today, and it is not going to improve—I can assure you. Unless we are willing to work together—all of us together—for a health insurance program, the relief load in our State will be primarily medical care. Already this relief load is reaching a saturation point—a point where the people can no longer afford to carry it. And by a health insurance program I

do not mean socialized medicine but a national health insurance program, approved by the American Medical Association, which shall provide that no matter how poor a family is, it will have to set aside one-half percent of its earnings—no matter how meager—for the time when that family will need medical care.

If we could have a national health insurance program, they would be relieved of a great part of this relief load which they now have to carry. There are many of them now, helping to carry this load, who cannot afford health for their own families.

I think there is a way, and we must work together to find that way in order to give our children an opportunity for good health which rural children do not have today.

Statement¹ of

DR. EDGAR J. FISHER, JR.

Director

**Virginia Council on Health and Medical Care
Richmond, Virginia**

During the past few years Virginia has made a great deal of progress in making her people more health conscious and in getting them to tackle their own problems and work out sound solutions for themselves. The stimulus for this movement has come from the Virginia Council on Health and Medical Care whose membership comprises almost all those groups in the State, both official and voluntary, which have a direct or indirect interest in health. The Council has assisted in developing a coordinated and well integrated health program for Virginia.

Distribution of Doctors

In order to strengthen the programs of our official and voluntary health groups, and to provide better medical care for all our rural people, we need a better distribution of doctors in rural areas. The Council is working toward this end and by supporting the Hill-Burton program, which provides modern medical facilities in rural areas, by supporting the 50 annual medical scholarships for students who pledge a year's rural practice for each year the scholarship is held, by supporting the regional hospital plan of rotating interns to

¹ Delivered at the Regional Hearing in Raleigh, North Carolina, August 25, 1952.

rural hospitals, and by administering a physician placement service. This placement service is available without cost to doctors who are looking for places to locate and to communities that are looking for doctors. For the first time, both doctors and communities have a clearinghouse to which they can come for help.

In the past, when a doctor sought a place in which to settle, he could write to the State Medical Society, the medical schools, the health commissioner or some friend. None of these had accurate and up-to-date information on openings throughout the State. In the same way, a community in need of a doctor had no central office to turn to for help. In many cases communities gave up trying to find a doctor, because they became discouraged.

Council Advises Communities

The Virginia Council on Health and Medical Care now advises with communities to help them help themselves to work out their medical care problems. This service is a pioneering one. The Council has moved slowly and soundly under the guidance of experienced physicians, rural sociologists, public health officials, and professional and lay health workers.

When a community comes to the Council for help in finding a doctor, it is investigated to make sure that a doctor is needed and will be supported . . . its director meets with the local people to tell them what the Council can do to help, what they can do to help themselves, and what other communities have done to get doctors . . . he gathers a great deal of detailed information about the community, which a doctor will want to know. He furnishes them with a list of physicians who have indicated that they want to locate in Virginia. From time to time he revisits the community to see how they are progressing and he tries to keep their enthusiasm up.

The Council does not go out to look for communities that need doctors. It waits for the initiative to come from the community itself. . . . During the past year the Council has worked with about 90 communities in trying to help them find doctors.

The Council's list of available doctors is made up of those who have either written in directly, or have been referred to it by the Medical Society of Virginia or some other group. They in turn are furnished with a list of communities that need

doctors. They are asked to write or visit the contact person in any of the places that interest them. If a doctor is a specialist, the Council tries to help him, although requests for specialists are limited. The Council has helped hospitals find staff residents and specialists, and it has helped established doctors find assistants.

As one means of acquainting young doctors with this service, letters are sent each fall to the junior and senior medical students at the Medical College of Virginia and the University of Virginia Medical School. These explain what help the students can get when they are ready to locate. When the young doctors leave the State for their internships, they are contacted and reminded of the Council's service and are encouraged to return to Virginia to practice.

This fall the Council will contact the seniors in the medical schools in our neighboring States offering the facilities of our service to them.

Everything is done to make it as easy as possible for doctors to find good rural locations in Virginia. As a result of the information which the Council provides to young doctors, we find that they are encouraged to consider general practice, and are encouraged to locate in Virginia when they might have gone to some other State.

Hill-Burton Program

Virginia now has 24 new hospitals and 13 new health centers either completed or under construction, as a result of her participation in the Hill-Burton program. It is felt that now the need is for medical service centers in which public health activities, local doctors' offices, laboratories and minimal X-ray facilities can be integrated with a few beds to which doctors practicing in groups may bring their seriously ill patients. This would lead to much more efficient and better medical care, and these facilities are less of a drain on the communities' resources than 50-bed hospitals. In Virginia, we are now preparing to operate clinics in two such medical service centers at the request of the local doctors.

Public Health

A strengthening and expansion of our public health program in Virginia is needed. Although on September 1 of this year, 91 out of our 98 counties will be covered by local health departments, some health officers are responsible for three and four counties. This is not adequate coverage. A

basic need for our public health workers is a salary scale which will attract and hold good personnel.

Mental Health

Virginia's mental health program is handicapped by the lack of State funds for the adequate maintenance and operation of our four State hospitals and the two colonies for feeble-minded children. Here again the salary scale for trained personnel is a major problem, and as a result our mental institutions are dangerously understaffed. There is a need for an expanded mental hygiene clinic program. There is also a need for an educational program which will reach the physicians, so that they will have a better understanding of mental illness. An educational program to reduce and do away with the stigma attached to mental illness is necessary.

Tuberculosis Control

Tuberculosis control needs of Virginia are basic ones—increased case-finding services and treatment facilities. Available beds fall short of minimum standards by more than 2,200. The disease is more widespread among the Negro population, yet per capita, fewer beds are available for them. The immediate and pressing need, therefore, is for more beds for treatment of Negro tuberculosis patients. Tuberculosis sanatoria in Virginia are understaffed and the personnel is underpaid. Rehabilitation and patient services are below standard and need to be improved and strengthened if full advantage is to be taken of available case finding and treatment facilities.

Cancer Control

The main needs in the field of cancer control are for a strong educational program, including reaching the physicians, more extensive use of the biopsy service, and making people more aware of the importance of tumor clinics spotted around the State.

General Hospital Beds

Although the Hill-Burton program has provided Virginia with many new hospital beds, hospitals still have waiting lists in some sections of the State. The need for additional general hospital beds for Negroes is very acute.

Voluntary Prepayment Hospital Plans

Every avenue should be explored to impress on our rural people the importance of enrolling in

voluntary prepayment hospital and medical plans. They should be educated to the same extent that our urban population has been educated, so that the now sizable enrollment among our rural people and Negroes can be increased.

Indigent Hospitalization

There is a need for studying indigent hospitalization plans to find the one which best suits the individual needs of each State. A good, sound indigent hospitalization program would be of great benefit to our rural people, and particularly our tenant farmers and Negroes.

Medical Personnel

With increased facilities at our medical colleges, more doctors, dentists, nurses, technicians, and allied personnel could be educated. Nurses, technicians and therapists of all types are badly needed to staff the new hospitals, and also to meet the demands of the established hospitals.

Recruitment Program

A recruitment program is needed in our high schools to encourage young people to train as registered nurses, practical nurses, technicians, dental hygienists, physical and occupational therapists.

Adequate Salaries

Again let me emphasize the need for adequate salaries for trained personnel in public health, mental health, and in the allied fields. We must encourage well-trained people to enter these fields of service. They must be adequately compensated so that they will not be enticed away from their important jobs, and thus place the health of our people in jeopardy.

The needs I have described are of vital importance to Virginia's rural and urban people whether they be white or Negro—tenant farmers or land owners.

Statement¹ of

REV. GARLAND A. HENDRICKS

Director of Church-Community Development

Gardner Webb Junior College

Boiling Springs, North Carolina

They tell me that when the first railroad was completed in South Carolina, the little wood-

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

burner train locomotive would pull a few coaches 12 miles an hour. The farmers became alarmed because word was whispered around that if they started running that contraption any faster, nobody could grow chickens along the railroad when the train came by, because the suction from it would swoosh them in, and they could not raise chickens—12 miles an hour, 100 years ago.

Now they tell me that you can have breakfast at the airport in New York, fly to Chicago, and order breakfast again the same morning at an earlier hour than you were already served in New York.

Something has happened in America in 100 years under the impact of modern science. And in the process of this something that has happened, the rural church is left holding the bag.

Rural Church in Community Life

There are more than 100,000 rural churches, little churches in small communities across America. In the last 50 years, we have been so busy building our towns and cities out of country people and rural resources that we tend to forget the place of the church, and we tend to forget the tremendous drainage of vitality from the rural to the town community.

I want to suggest in line with some studies that have been made that 75 to 80 percent of all social participation of rural people is through the church. I want to suggest that the rural church is an agency through which the health of our people will be lifted. It is the basic institution in community life. Seventy-eight percent of the social participation of rural people in North Carolina is through their churches, and only 22 percent through schools, civic clubs, farm organizations, and all the other organizations combined.

The rural church for 50 years has been so busy making its contribution to the building of modern America that it has been extremely weak. But the rural church is beginning to awaken. There are rumblings of new vitality in the country community, and things are on the move for a change.

Role of the Church in Health

Now, in the process of building urban America I think we are coming to the heart of matters as we look at the health needs of our country—when we recognize that the minister, the local church, and the religious denomination constitute a vital

area in which and through which we shall have to work.

A first observation is that the church by its nature is interested in the health needs of the people. The church was conceived in a desire of God to lift man out of despair. The fellowship of sinners, which constitutes a local church, is also struggling for the complete, the wholesome, the holy, the total life.

The church is dealing always with laws, fundamental principles of life which are as applicable in one generation and in one part of the world as in another. The church is the motivating agency of life. It touches deep into human nature and deals with the basic issues of the thing that makes man different from the other creatures in God's world.

By its nature, the church wants everybody to be strong physically so that they, in their cooperative endeavors with God, can have an effective life in His world.

Ministers Cooperate With Doctors

Some of us know that there are times not to pray in the room of a sick person. There are other times to pray. And the modern minister in the country community is learning to use the Scriptures and prayer by the bedside of the sick, in the home, and in the hospital, in a skillful manner. He is learning to relate the resources that are available to the needs of his community.

I know ministers now who are taking an active part in distributing printed information about health needs and about some of the major diseases which threaten life in our land. We are coming to grips with that sort of thing.

Ministers are getting acquainted more and more with physicians. They are learning the art of dealing with people in personal counsel, and they are learning to cooperate with doctors in their communities so that the minister may help to satisfy the emotional need of a patient while the doctor works at the physical need.

The younger minister, and some of the older ministers who are awake to these basic needs of our time, are facing these things in life and are building for better health in the future as rural America comes back into its own again.

Then the local church can do some things and is doing things in places. The local church is insisting on the spiritual implications of a strong body and a sound mind. Local churches are put-

ting in projects of work now; e. g., recreation, health meetings, and are informing their people along various lines. The church is seeking out the indigent and needy and trying to interpret what is best to be done for them and trying to guide them to the right agency to help them.

The churches are cooperating with other agencies, school and farm organizations, and sociologists and others encouraging people to evaluate properly the appeal for funds that comes to the church people when financial support is asked, and so on.

The churches are beginning to awaken to things that they can do, and the churches across the South are interested in doing things a new way.

In closing, let me say that the denomination can do something and is doing something.

There are 7,000 ministers in the colleges and seminaries of this denomination that has 9,000 untrained ministers. The tide is turning and turning fast. Our churches from more than 100 years back have sponsored the building of educational institutions, hospitals, clinics, and other agencies, and some local churches are beginning to sponsor medical services through nurses, through local clinics, and so forth. They are publishing information about the threats from dope and alcohol and things of that kind, and the church recognizes that health is a world problem and not just a United States problem; that disease germs go across oceans, and in the mission program of the church, it is sponsoring hospitals and clinics and medical services as just as vital a part of the Christian Mission as preaching the Word from the pulpit.

Following is the prepared statement of Reverend Garland A. Hendricks.

The Church Recognizes Health Needs

There are more than 150,000 rural and small community churches in the United States. A survey made in North Carolina in 1949 revealed that 78 percent of the social participation of rural people was through their churches, and only 22 percent through schools, civic clubs, professional organizations, and other agencies. Studies in other States give a similar picture.

Consolidated schools have broken across community boundaries and loyalties. Rural people are not highly organized along social and pro-

fessional lines. They are religious, and the church is nearer to them and affects their thought and action more than does any other agency. Obviously, the church is in a position to have a profound influence upon the health of the rural people of America.

By its very nature the church is concerned about the health of people. The church was conceived in a desire of God to lift man out of his own despair. The Son of God sacrificed His flesh and blood for despairing men, sick of body, mind, and spirit, and He called upon all men to engage in wholesome life.

Across the centuries, while nations have risen and fallen, men have continually gathered in groups to consider their relation to God and to one another. These fellowships of sinners have struggled to attain the complete life, and despite all human frailties they have been instrumental in making life more desirable. Wherever there is a church we have the most severely tested institution known to man.

The church deals in divine principles, laws of God as fundamental to the well being of man in one time as in another, as applicable in one way of life as in another. Its major concern is the dignity and welfare of every human being. It is the character-building institution of society, supplying ideas, ideals, and motivations which cause individuals to live together in groups in a desirable manner. It is the instrument through which God works to make man know good from evil.

It is the function of the church to motivate individuals to participate in acts of worship, forms of government, professional activities, and services to others which are good and for the well being of all. The church opposes schemes and programs designed to promote personal gain to the hurt of others, be this in government, profession, or service organization. The church speaks to every person the promise of the Son of God, "I am come that they might have life, and that they might have it more abundantly" (John 10:10).

As the church pursues the life abundant for everyone, the minister leads the way.

A well-rounded minister pronounces those great doctrines of the Bible which deal with healthful, complete living. He remembers, "Stand perfect and complete in all the will of God" (Colossians 4:12). He interprets, "Be ye therefore perfect, even as your Father which is in heaven is perfect"

(Matthew 5:48). In every aspect of life a man is to strive to be at his best.

A spiritually-minded minister describes the intimate relationship between the spiritual and physical nature of man. He understands, "Your body is the temple of the Holy Ghost which is in you, which ye have of God, and ye are not your own" (I Corinthians 6:19). A healthy person is God's most useful coworker.

A practical minister shows his people how man is related to a proper care of the resources of the earth. He preaches, "The earth is the Lord's and the fullness thereof; the world, and they that dwell therein" (Psalms 24:1). To do right towards God's holy earth is to guard and protect the food and water supply, to preserve the nutritional value of the soil. A depleted soil will no longer support healthy rural or urban people.

A sympathetic minister offers premarital counsel so that he may establish a spiritual foundation for family love and home life. Then he offers prenatal and post-natal counsel to direct prospective and new parents in the art of religious living. This gives them inner peace, and assures a wholesome atmosphere for the growth of a healthy child.

A visiting minister encourages beauty and cleanliness. He knows when and how to make suggestions. Thus he shows his people the way to preventive measures.

A wise minister makes skillful use of the Bible and prayer in the presence of those who are ill. There are times not to pray, and there are times to pray. There are ways to pray, and ways not to pray. To be able to use a passage of scripture and a prayer at the right time is an art which may have great value for a sick person.

A wide-awake minister informs his people on such matters as child welfare, private and public charities, welfare of the aged, preventive practices, curative measures, specialists and their services. First of all, he must know the facts himself.

A friendly minister makes personal acquaintance with physicians, nurses, those who can assist the mentally ill, and welfare workers. Then he can cooperate with all who work for the betterment of health, and they can work with him.

Many who serve as ministers in these 150,000 small churches in our land are giving themselves unselfishly to such activities as listed above. Unfortunately, thousands are untrained, some are

ignorant of modern health needs, and not a few are prejudiced and hostile to the better practices.

It will be necessary for institutions of learning, medical scientists, and health agencies to inform all the ministers of our country. They hold a key position in the life and thought of the people. They can be counted upon to lead the people as far as their understanding and insight permit.

A local church is in a position to meet health needs in its community.

A church with spiritual dynamics recognizes the spiritual implications of a strong body and a sound mind. Physical strength is a means of more effective service to God and man. Where people look upon themselves as brothers and sisters, they are friendly and willing to help one another, are God-conscious and grateful for the daily blessings of life. This kind of motivation creates a community atmosphere wherein every person is challenged to be strong and useful. Life has an abiding purpose.

A progressive church is always seeking new and better ways to promote the welfare of all its people. It projects a recreation program to relieve tension and preserve mental balance. It sponsors the building of a community clinic and secures the services of a young doctor. It distributes literature informing the members about such dread diseases as cancer, polio, heart weaknesses. It makes public announcements about health meetings and clinics. It provides the services of a trained nurse who spends her time educating the people in preventive measures. A health committee informs the people about insurance, care of the sick, and welfare of the aged.

A generous church contributes to the support of charity patients, provides an educational program for its people, and seeks out persons in need. It gladly contributes to research.

A cooperative church works hand-in-hand with other churches of the area, schools, farm organizations, civic clubs, youth groups, health officers, physicians and nurses, soil conservationists, and others who promote better health.

An informed church calls upon its people to face the facts about food values, health habits, nutrition, sanitation in food and water and drainage, insect control, housing, working conditions, and diet.

An alert church is careful to evaluate every appeal for funds, for moral support, or for support

of an idea so that its people may be protected from quacks, false prophets, and worthless causes. The faith of our people must be sustained in agencies and projects which are beneficial.

In all that it does a local church is the conscious stimulating power of its people, a guiding light, and an informing medium. It seeks to guide them into such activities and practices as will help them help others.

In a free society in the United States we have banded ourselves together into like-minded groups which we call denominations. Each denomination consists of a large number of local churches. A denomination of churches works to promote better health.

A freedom-loving denomination trains its ministers well so that they are conscious of both health needs and ways of meeting those needs. Some theological seminaries are now training young ministers in soil care, teaching them how to do personal counsel, and informing them about the structure of community living. Ministers are being prepared to come to grips with every aspect of a person's life.

A health-conscious denomination sponsors clinics, hospitals, medical schools, nursing schools, orphanages, and homes for the aged. Such institutions have proven that churches can play an important role in medical research, special surgery, and clinical services.

Most denominations have their own publishing houses and social service commissions, through which they distribute vital information to the churches about alcohol, dope, sex diseases, and other ills.

A world-conscious denomination recognizes that health is a world problem. Diseases cross oceans and continents. Proper diet is as necessary for one race and nationality as another. Church mission work emphasizes health through physicians, hospitals, clinics, health education, and agricultural missions.

In more than 150,000 small communities in the United States and in our larger communities the church recognizes health needs. Ministers, local congregations, and denominational leaders are honestly trying to apply the laws of God to the everyday living of people so as to make healthier bodies, minds, and spirits. They recognize that God can use healthy people more effectively to bring the abundant life to all.

Statement¹ by

MRS. BERNICE LUXFORD

**Oregon Farm Bureau Federation
Salem, Oreg.**

Health Needs and Medical Care

I am here representing a large rural population. It is with pleasure I can say, according to available statistics, that I am from the healthiest State in the healthiest Nation in the world.

First it is necessary to ascertain what we mean by "health needs." We need to make clear the difference between health needs and medical care. Medical care is a purchasable service, but our total health is our personal responsibility wherever we live. As individuals and groups, we must assume a share of the responsibility for health. In discussions with rural groups, I find it necessary to go one step further, that of making a distinction between needs and demands.

As a member of the Oregon Rural Health Council, representing Farm Bureau, I have had the opportunity to know of the needs in health and medical care in Oregon on an over-all picture. At our last conference—held in December 1951, which was attended by more than 200 persons representing all major rural groups, i. e., farmer, PTA, etc., professional groups, i. e., doctors, dentists, nurses, and voluntary service organizations, i. e., American Cancer Society, Oregon T. B. and Health, etc.—conclusions reached after 2 days of conferring were that the following could be considered health problems or needs:

In the matter of physicians it was concluded that the over-all supply of physicians and dentists is reasonably adequate and that this supply is assured for the future by (a) steady expansion of the medical school; (b) a heavy surplus of candidates for medical education over the available training facilities. At present the enrollment as freshmen is 75, but with increased building already voted and approved, this will be increased 15 percent.

Physicians

The Oregon Physician Placement Service has just completed an analysis of the distribution of physicians in the State. The tabulation reveals a steady increase in the number licensed and registered. The annual increase has persisted in spite

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

of the substantial inroads made on Oregon's physician population by the armed services. Eighty-nine licensed Oregon physicians are now in military service. * * * At the present time the physician population ratio is one doctor to 910 people. This is an enviable position. * * * Transportation lets many people adjacent to urban areas have ready access to good quality medical care by competent physicians. * * *

Nursing

There is a problem of shortage as well as distribution. There is thus the problem of recruiting into the profession and into rural areas. The Women's Auxiliary of the Oregon State Medical Society has a local project for the stimulation of recruiting of nursing students. At present they have in effect 12 scholarships for girls wishing to enter nurses' training. In some of our very fine hospitals male student nurses are being admitted to accredited training courses. This should help relieve shortages in some fields of nursing.

Too, it is with pride that Oregon points to her inclusion of all races and creeds in the solution of our health problems. As an example, the president of a graduating class from Good Samaritan Hospital was a Negress. Practical nurses are another solution to rural problems in nursing, which also would relieve hospitalization of patients.

Hospitals

It was reported that Oregon at present has 5,109 hospital beds. Oregon's total hospital bed need is estimated at 6,912. Since some of the beds now in use are obsolete or not acceptable, the proportion of current need met is 66 percent. There are some areas where hospitals are badly needed. It is felt that small clinic or medical centers for rural areas might be the answer to this problem, using our large hospitals in urban areas for major work.

It has been amazing to find that many communities prefer to raise their own funds for a small compact medical center rather than partake at the feast table and use Hill-Burton funds, which makes the amounts to be raised by themselves higher than might actually be needed.

Prepayment

In the matter of prepayment for medical care, it was inferred that the present policies offered do not cover all that could be desired, but by working with the various insurance companies, Farm

Bureau was able to obtain a policy that met with approval of majority of our members in that it did cover many of the ailments and accidents more common to farm people. Too, we advocated that voluntary insurance plans institute the practice of deductible policies so that the purpose of voluntary medical care insurance becomes that of taking the shock out of the large catastrophic costs.

Medical care insurance should provide for improving the scope and quality of medical care for the insured population and should promote prevention of disease and facilitate its detection at an early stage.

Migrant Workers

Migrant workers do constitute a community problem insofar as health is concerned. At present the Farm Bureau has a committee working with the Public Health Department, to set up a plan for housing and sanitation for farmers and growers to use; so far Oregon has had no standards for this.

As far as members of the Farm Bureau are concerned, we are still individuals with the rights and minds to think and do for ourselves. It is our contention that the above mentioned problems can be worked out by personal and community endeavors. To this end we have formed the Oregon Rural Health Council, composed of representatives from all agencies and professions interested in health.

In turn, through the efforts of our rural groups, we are forming local county councils. These councils are actively working on surveys to determine the needs of the people in their respective counties. It is necessary to know what we need before we ask for help, at home or elsewhere.

Rural Public Health Education

The main work of the councils will be education—teaching rural people how to use the medical services efficiently, nutrition, sanitation, immunization, home nursing, suitable clothing for outdoor occupations, and last, but not least, prevention of accidents. In Oregon the main cause of death in rural areas last year was suffocation, with drowning as second cause of fatalities.

Now, what can all the doctors and hospitals and medical care do if people will not be responsible for their own actions? It does no good to go to the doctor or hospital to be cared for after falling from a broken ladder, then go back home and climb up on the same unfixed ladder and fall

again. If we get malaria and we go to a doctor for treatment, then come home and fail to get rid of the breeding place of the mosquitoes, then no matter how good the medical care we could not keep good health.

Good Health . . . From the Roots Up

Our rural areas are not all farm populated. The health of the lumber worker, the fisherman and all others in those communities in rural areas affects all of us, but we feel these groups must show some personal responsibility to themselves too. We still are the main source of revenue from taxes in the State of Oregon.

The farm families of America have been termed the backbone of our Nation. Why? Because they have subscribed to the philosophy of individual independence.

We, like our doctors, are out in all weather; many a night is spent in a drafty barn or shed with a cow or calf or lambing a flock of sheep. The wind blows in the fields. Through all this we have become, by our very independence, one of the most potent political factors in the life of our Nation.

We have come a long way since a truly great farm woman went to the AMA 7 years ago and asked for cooperation in solving rural health problems. She got that cooperation, and because of it we of Oregon feel that today we have no urgent nor pressing health problem that cannot be solved by our own people in our own way. We are helping ourselves to health.

Oregon Farm Bureau, as well as the American Farm Bureau, are on record as opposing any Government interference in our present health problems that we ourselves can continue to improve, and, as we teach our children through the 4-H, "Make the Best Better."

We, as farmers, know, "Good health, like good corn, starts growing from the roots up; not from the tassel down."

**Statement¹ of
DR. R. V. CAVINESSE
Raleigh, N. C.**

The Small Farmer

I think we have three angles of approach to this problem today dealing with the rural population,

the large Negro population, and the very large tenant farmer population. I think that those three, for all practical purposes of this discussion, can be grouped into one—that is, the small farmer. His race or color makes no difference. It makes very little difference whether he owns his farm or whether he is a tenant farming on halves, thirds, or quarters. And at the end of the year he comes up with an income of less than \$25 per week, net.

That is the group that has the low income and that is responsible for the South being referred to as the number one economic problem of the Nation. These people secure a very poor living, far below generally accepted standards of living in this and other areas.

However, they do secure all the medical care that they really wish to have. The medical profession and the hospitals are offering adequate care, very often, to the majority of these people entirely free, physicians generally making heroic efforts to see to it that adequate medical care is furnished to everyone, regardless of economic status, and they are doing it with very little compensation from this group of patients.

It is true that they do not accept all the medical care at times that they may need, but that is equally true of all groups. However, it is available for them for the asking.

Failure To Use Services

This was prepared by a group of physicians in Raleigh. We operate our charity clinics. It would be quite interesting to all of you, I think, to realize how often we tell the charity patients to come back to the clinic, and they do not do it. The same is true in doctors' offices, where they treat charity patients without charge—low income patients—and they do not come back as often as they are instructed.

For that matter, I wonder if anybody in this room throughout his life has secured all the medical care that he needed and that was available to him. I have not—and I doubt if anyone else has—and I think that that is a factor that should be considered in evaluating any group of statistics on any such subject as this.

Small farmers become accustomed to accepting "handouts" from the Government. During the past 20 years, they have been forced by necessity to become more and more the recipients of charity, which at times is referred to as a dole. That

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

charity comes in the form of support prices for crops based on a partial percentage of the 1910-14 average production costs.

Now, no matter what sort of deal we call this, the effect on the small farmer is the same, and as a result it has placed him at the bottom of the economic scale in America. For these small farmers need better insurance and financing programs. No doubt they do. They need a great many other things. But how in heaven's name can they pay for it with a net average income of less than \$25 a week the year round with a big family to support?

Low Income—Basic Problem

The one, and only one, fundamental problem of this group of small farmers is that the average family income is less than \$25 a week. They have very little opportunity of improving their lot. The average annual income of the North Carolina farm population—that is, per capita—is \$670, as compared to \$2,300 in Iowa.

The position of North Carolina in farm income is number 38 in the Nation. This figure of \$670 a year in North Carolina is the average for all farmers, including the big operators, for whom large profits are legitimately possible.

In the past 20 years our small farmers have had to learn many trades in order to survive on the farms in a paternalistic government. Many of them are moving off the farms in order to earn a living. In the cities and towns, or in the country, these small farmers, working at new jobs as trainees, carpenters, automobile mechanics, textile workers, and so forth, easily earn from \$60 a week or more to \$150 a week. Minimum wage laws do not apply to farmers.

Many farm wives working in industry now earn much more in 40 hours than the entire family can earn on the farm working full time for the entire week.

Our North Carolina farmers as a group are good citizens. They are honest, industrious, hard-working people, just as good as any other group of laborers, and they would like to be self-sustaining. They work very long hours in an effort to become so. Discrimination? Yes, definite discrimination, but, as usual, it is not discrimination against any race, but it is discrimination within a race, an array of class against class.

Farmer at Disadvantage

Is it possible for anyone to think that the answer lies in increasing the dole to farmers, as suggested by the proposed better insurance and finance programs? How can this group pay the cost of better insurance and financing programs? Or should they be made the recipients of further doles? Should we increase the paternalistic activity of our welfare State?

In the interest of keeping the self-respect of our citizens, the answer to all of these questions must be no. The farmer has been placed where he is by the Federal Government, and it has been done deliberately in an effort to keep the cost of living down for everybody except for the farmers. Every organized group of laborers has had Government support for wage increase after wage increase. Of course, everything that the farmer needs has had to rise in price to help pay higher wages for everyone else.

Parity prices today take care of very little of this increase in costs. So the small farmer is left holding the bag. The reason is to help the paternalistic government keep living costs down for everybody except the farmer. The so-called parity prices are based on the average of production costs of crops from 1909 to 1914. The Government seems to think it is being especially generous in offering these farmers 80 to 90 percent of parity prices. There are many things considered now almost a necessity, but they are not considered in this group.

Living costs are now near the all-time high. There is adequate and ample reason to believe that they will continue to rise. Farmers receive the blame for this, based on the high prices paid by consumers for farm products. But the farmer receives a small part of the consumer price for food.

Processing and handling charges are very much greater than ever before. Every time a labor dispute is settled, living costs go up, and the cost of producing food rises. That seems to be taken as a matter of course, but the farmer gets none of it except the blame for high food costs. His operating costs go up with everything else.

The remedy would be difficult and cannot be accomplished by continued socialization.

Remedial Measures

First, we must consider the damage already done to our farmers by turning to the Government in the

last many years. There are many intangible results, largely psychological and physical, and there are also many tangible results. Our national population is increasing by a rate of almost 2 percent a year. Yet the percentage of the population engaged in farming is decreasing by 1 percent a year. This will rapidly lead to famine in the country, if it is not checked.

Secondly, the farmer must have more income in order to become self-sufficient, in that he may have greater buying power, that he may produce more economically, and produce foods of better quality. Also, it is only in this way that the farmers can, as a group, become better citizens.

Third, cash receipts for farmers for foods produced on the farm are so small a part of the national cost of living that food prices at the farm could well be raised, doubled or tripled in as many instances as are needed to give the farmer a square deal without effecting any very great increase in the over-all cost of living for the Nation.

Fourth, the present charity handouts for the farmers, whether called doles, soil-conservation payments or any other name, are too small to be of much practical value to the farmers. They are not able to buy the proposed better insurance and financing programs, nor would their self-respect be raised or supported by any other socialization such as compulsory insurance of any type, socialized medicine, or other additional farm subsidies. Any such attempt would only plunge us deeper into our socialistic world and closer to the so-called Russian type of communism. Any reasonable, practical cure or remedy must be based on an attempt to equalize income so that the farmer can earn equitable wages comparable to the wages of other groups of laborers.

Parity Payments

Parity, of course, must be raised. Since it is charity, it is objectionable, but it is now being used by politicians as a tool to keep down the cost of living. It would be disastrous to stop payment suddenly, but if it is continued until other plans can successfully be put into operation to give sufficient income increases to put farmers on a true parity of income with other divisions of labor, then the present system of parity would no longer be needed and could be discarded.

When farmers can receive adequate incomes in relation to other groups of labor, the farmers will be able to produce at a reasonable price what the

country needs and be able to pay for everything else that they themselves need, if they are just given a square deal.

Statement¹ by

DANIEL RUSSELL

President

Texas Rural Health Council

College Station, Texas

Studies Show Widespread Health Problems

Studies made by the Department of Agricultural Economics and Sociology over the last 4 years on the health problems and needs by types of farming areas in Texas have shown that there is a widespread problem of health in rural areas in Texas. No area is clear of the problem of infectious and degenerative diseases.

Although it has generally been thought that the eastern part of the State is the area of high incidences of disease, the morbidity rate in west Texas is very high, especially in childhood and in cases of respiratory diseases. This may be due to the fact that there are very few approved public health departments west of San Antonio and Fort Worth.

The most important finding of this study has been the inadequacy of available statistics on health among rural Texans. This inadequacy cannot be blamed on the Public Health Department. This department was very cooperative with us in every respect in this study. About 200 Texas counties—most of these rural counties—have no approved public health department. The inaccuracy of these statistics can be traced to four facts:

First, many of the doctors in the counties which do not have public health units do not report their cases of infectious diseases to the State Health Department. Second, some doctors have not made correct diagnosis in some of the infectious diseases they did report. Third, many rural people have infectious diseases, often serious in nature, that are not treated by a physician. Fourth, many rural people suffer from temporary and chronic diseases and do not realize it.

A field check was made by interviewing and examining the records of five of the six doctors in a rural county. One doctor did not cooperate in

¹ Delivered at Regional Hearing, Dallas, Tex., August 18, 1952.

the study. The official State health records showed that there was no venereal disease in the county. However, the records of one doctor showed that he treated 150 venereal cases during the year for which the statistics were used. Four of the other five doctors treated 250 cases.

Statistics Inaccurate

Other inaccuracies were found in the official statistics of the county. The following diseases were not shown, yet the records of four doctors show they treated the number of cases listed: influenza, 250; chickenpox, 100; diphtheria, 6; dysentery, 165; malaria, 11; measles, 230; mumps, 240; tularemia, 1; typhus fever, 13; undulant fever, 4; whooping cough, 50; pneumonia, 4; poliomyelitis, 2. Official statistics show three cases of tuberculosis; the four doctors treated four cases.

In a check made in Brazos and Smith Counties, where there are good local public health departments, the official records of the State Health Department and those of local doctors were nearly the same.

Second, official health statistics are inaccurate because of the incorrect diagnoses of a few doctors. The best doctors admit they sometimes make mistakes in their diagnoses. The doctor practicing in a sparsely settled area without the benefit of modern laboratory equipment would naturally be expected to err more often.

In a check made in one county showing a considerably higher malarial disease rate than similar adjoining counties, it was found that one doctor practicing over a large part of the county diagnosed most all of his fever cases as malaria without any laboratory check. Another doctor in the same county, using laboratory methods, said he had found only a small percentage of the fever cases to be malarial fever.

A third reason the official State statistics on health are not reliable is that people often have serious ailments and get well without calling a doctor. For the past several years, rural children who have had infantile paralysis have been brought to the annual Twelve-County Crippled Children's Clinic at College Station. These children have been treated at home and recovered without a doctor having seen the child, despite the fact that some part of the child's body is left impaired by the disease.

Whooping cough, measles, influenza, mumps, and other common infectious diseases are often treated at home without the case ever being recorded.

Farm people have chronic, sometimes serious ailments for long periods of time without seeking medical attention.

A fourth reason, rural people generally are slow to complain about physical ailments and they give in to illness only when it is impossible to continue their daily routine. Farm people often have temporary illness and get well without stopping work.

Four Basic Needs

Recommendations: This study indicates clearly four basic needs for rural health in Texas:

First, there is immediate need for thorough research on the rural health situation in Texas. This will require intensive field studies in some sample rural areas of Texas to reveal the facts. The ideal arrangement would be a research project with rural sociologists and economists cooperating with nutritionists, soil scientists, doctors, dentists, public health officials and nurses, for the purpose of making a complete health study of the people in the sample areas. We cannot know what the rural health problems and needs are without this intensive study.

Second, we need to educate the people to become health conscious and to live healthfully. Schools, agricultural agencies, civic bodies, medical groups and individual citizens should cooperate.

Third, we need to develop sanitation, immunization and protection against infectious and degenerative diseases. Although the role of the practicing physician is vital, this is a public health responsibility. In this, the American Medical Association and other medical societies agree. Because of inadequate funds, about 200 counties in Texas are without approved public health facilities.

A state plan similar to the Gilmer-Aiken plan for education is needed for public health in Texas in order that the poorer counties may pay for their public health facilities according to an economic index of their ability to pay.

Fourth, the rural people in Texas need more and better medical service than they now have in their reach geographically and financially. Many medical and related bodies recognize this problem and are trying to work out solutions.

Health is one of the most important considerations in life. Fine farms, education, money, modern conveniences mean little to people who are ill.

Cooperative Hospitals

After the passage of the Permissive Act of the Legislature in 1945, Texas has led other States in the organization of cooperative hospitals. These hospitals with prepaid medical service show real possibilities of meeting health needs in rural Texas in communities favorable to such institutions and large enough to support such hospitals.

In 1948, Miss Helen Johnson in her study found 23 such cooperative associations in Texas. Only 17 were operating, however, and 2 had dissolved. Some of these are now operating with a paid medical staff officer and some without the services of such an officer.

In a study by Mr. W. C. Rohrer of the Texas A. & M. College, Agricultural, Economics and Sociology Departments, on cooperative hospitals in the United States, with special emphasis on Texas, it was found that there are about 10 things that make for success in rural cooperative hospitals. These things should be taken into consideration by communities planning cooperative hospitals.

Texas leads the Nation by far in this movement, which is a plan to bring medical and hospital service to many areas in Texas which have no adequate service at the present time. It is also a plan to keep down state medicine, which will surely come if we do not meet these unsolved problems of health in our rural areas in the United States. All of us should bend our efforts toward making these privately owned farmers' cooperative hospitals a success.

Cooperative Hospital Needs

The success of these cooperative hospitals requires that:

(1) The people of a rural community be educated as to the aims of prepaid medical care.

(2) The separate communities of the area and the occupational groups be fairly represented on the hospital board of directors.

(3) The support of community leaders be obtained in establishing a rural cooperative hospital. Farm leaders, and ministers are the most frequently mentioned supporters of a rural cooperative hospital project. Others frequently men-

tioned as supporting a hospital's establishment are editors, county extension agents, and chamber of commerce managers. Local doctors are mentioned occasionally.

(4) Cooperation of community organizations in establishing a rural cooperative hospital is essential to the success of the association. Community organizations often mentioned as supporting the organization of a rural cooperative hospital are farmer cooperatives, chambers of commerce, and farm organizations. In one return the State medical association was credited with assisting in organizing a cooperative hospital, but this group excluded prepaid medical care.

(5) A rural community may need a hospital and medical care, but establishing the rural cooperative hospital may not succeed if the income of the area is not high enough or is not well distributed among farmers and businessmen.

(6) Financing the hospital is a big problem. Without sufficient funds to build, equip and maintain a hospital of the right size and scope, there cannot be a successful rural cooperative hospital. The hospital must be supported by the rural people by their money contributions.

Problem of Dues

(7) A successful rural cooperative hospital will charge at least \$50 for a life membership, and future charges for life memberships will probably be more than \$50.

The charges made for a life membership in the nine rural cooperative hospitals are \$50, \$75, and \$100. Five of the hospitals in the study have \$40 fees. Three of these were established in days of lower agricultural prices, which may account for the lower fees. The other two charging \$50 membership fees seem to be the least ambitious hospitals in the study, as far as financing is concerned. One association has a \$75 fee and three charge \$100.

(8) Annual dues should be small enough to insure a sufficiently large membership to assure adequate prepaid medical and hospital care. Within these limits the amount of annual dues charged does not seem to be related to the success of the hospitals. A large membership helps reduce costs of medical care through decreasing per capita overhead costs.

A wide range in dues is charged by these hospitals. The heavy incidence of annual charges

falls around \$16 to \$18 for a single person, \$24 to \$25 for a family of two, \$30 to \$32 for a family of three, and around \$36 for a family of four. There is a variation of charges for families of more than four persons. The annual dues cover the bulk of the costs of illnesses and hospitalization for the members of the hospital association.

(9) Preferential rates to members for some medical and hospital services will provide incentive to join the association, thus increasing the hospital's chances of success.

Most of the charges made for medical services are much lower to members than to nonmembers. The association which does not offer a big savings to members is the most modestly financed hospital of this study. With small dues and low membership fees the prepaid program necessarily will be limited. The large item of expense in medical service is the doctor's fee. When this is prepaid, savings result.

Doctor Staffing

(10) A finished hospital building fully equipped and furnished is of little value unless it is staffed with doctors. One of the primary aims of the rural cooperative hospital movement is to bring doctors into the rural areas. The problem of securing competent personnel is important. At times organized medical groups have prevented hospital associations of this type from getting doctors.

Opposition from doctors has prevented the establishment of hospitals in a number of rural communities. A few rural cooperative hospitals have been and others may in the future be organized and staffed in the face of opposition by professional medical groups. It is difficult, however, to visualize any widespread development of this type of medical service without some cooperation, or at least lack of opposition from organized medical societies.

(11) The presence of successful cooperative enterprises in the rural community is a factor determining success. One association reports: "Previous success in cooperative enterprise in the area has much to do with our success." Another says: "The fact that other cooperative health plans have been organized in not too distant communities is a factor making for success of the rural cooperative hospital."

Statement¹ of

R. FLAKE SHAW

Executive Vice President

North Carolina Farm Bureau Federation Greensboro, N. C.

I shall confine my remarks more specifically to that part of the subject matter that deals with this 15 percent of our population that lives on farms, and still diminishes. That is a rather important group of people, in my catalogue, because of the fact that they do produce the food and the raw material for new wealth in this country. And I am delighted that this meeting is giving some consideration to see how we can best serve in a general way the medical needs of this type of people.

I represent the North Carolina Farm Bureau. That is one of the State organizations that makes up the American Farm Bureau, which has 1,500,000 family memberships of farm people in this country.

The majority of that membership is in the South and in the Midwest. They have been interested in this health problem for many, many years, through the national and different State organizations, and we have attempted to work at it as best we could. But our first assignment as an organization is to watch the dollar mark for the farm people. That is really what our problem is.

With just 15 percent of the people living on the farms and earning 9 percent of the national income, or a little less, you cannot expect these people to have as much of everything as most other people do. That is the average. And, of course, when you take the tenant and low-income group, it comes far below that portion of the income.

Now, in attempting to work at the job in this State, we have a full-time employee on our staff, a Negro man who works with the Negro farmers of North Carolina. He enjoys the distinction of being the only man in the United States who occupies a position of that type. We are doing all that we can, with our limited resources and personnel, to service the rural needs of North Carolina, whether they be health, income, education or whatnot.

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

Health Insurance Lacking

I have a family of 13 Negroes living on one of my farms. Those Negroes have a good income, and if you did not see five Buick automobiles sitting in the road as you passed by there, you would think that they were using their income in a very good way, because it is a good-looking farm and has running water; the house is painted and it has electric lights. You would not see any difference, but you would see 5 automobiles in that family of 13 sitting in the yard of that house if you arrived there this afternoon. They all belong to that family. I doubt if any one of them has a health insurance policy, because I spend money every year on them to go to the hospital in different places.

Now, it is part of my responsibility to sell them on the idea that they can enjoy something besides automobiles, and they need something besides automobiles. However, they have fairly good health. But that is one point that we have to recognize, that these people are free Americans, and they are going to spend their incomes as they want to spend it, and they are not as bad off in some instances as a great many people would have you believe.

Bread and Butter Service

In addition to having plenty of good food, if they are willing to work for it, they have a fairly respectable income, a lot of them.

Now, we have to get back to this community and get where the problem is, and you have to sell the leadership in that community on the fact that they need to do something about the health program there. And it can be done in any county.

If you call in the doctors and the businessmen and the bankers and the leading farmers and get them to analyze completely and realize what the problem is, and then they will start out by seeing how far they can go to meet the challenge, how much of the work they can do themselves, these problems can be met—maybe not in a hospital. Maybe they do not need a hospital. But I like Dr. Bond's expression of "bread and butter service" that will meet 90 percent of the needs of many of these people.

We have made some start in our organizations in this State. . . . As a rule, our people are made up of the type that you do not have to pay to come to a meeting. They have built this organization on a voluntary basis by giving freely of their time, and they are designed after a pattern

of principles that is flexible enough to use that outfit for anything that that community needs, whether it be for health or . . . schools, or whether it be for churches, or what have you.

Statement¹ by

VON T. ELLSWORTH

Director

Department of Research

California Farm Bureau

Berkeley, California

Farmers Suggest Insurance Improvements

During the last two decades the farmers of California have given a great deal of thought and attention to their health needs. We feel that during that period of time a great deal of progress has been made in meeting them. We note a marked increase on the part of the California Medical Association in their rural health conferences each year, and feel that that organization is providing a great deal of leadership and a great deal of information to help us materially along this line.

Over the years we have had some experience with voluntary health insurance programs, and we believe that a great deal of additional funds are now being provided by the recipients of health services which prior thereto had not been paid. We feel that much can be accomplished along that line.

If I were to make a specific suggestion for improvement in that field, it seems to me that it might be in the matter of forms. It would seem to me that leadership such as your Commission, or something comparable to it, might call together the various interested parties and endeavor to simplify and unify the forms used by the various health insurance organizations.

It seems to me that that would particularly popularize the movement, from the point of view of the hospitals, and also the physicians and their attendance problem would not mean so much to the individual, but surely it would increase the popularity of that phase in that form of meeting our health needs.

California, as you know, stands second to Wisconsin only in the United States in prevalence of county hospitals. We are a county hospital State,

¹ Delivered at the Regional Hearing in San Francisco, California, September 29, 1952.

and over the years, as an organization, we have endeavored to expand and extend the use of those institutions. We believe that some accomplishment has been made along that line. Our State, like others, is suffering in rural areas under the lack of facilities.

The city of San Francisco today, for example, with its example of about 350 population per doctor, is in contrast to something like 3,000 for our more sparsely settled areas. That, of course, is one of the penalties that rural areas must bear, due to the sparseness of their population, but anything that could be done, or suggested, along that line, it seems to me, is one of the needs of our State.

Statement¹ of

H. E. SLUSHER

President

Missouri Farm Bureau Federation

Jefferson City, Missouri

We would invite the attention of members of the Commission to the 1951 resolution of the American Farm Bureau Federation relative to rural health, which we quote as follows:

Rural health: The interest of rural people in better health is increasing. They are taking steps to provide more adequate medical, dental, hospital, nursing, and public health care in an increasing number of rural communities. More physicians, nurses, and hospitals are needed in many areas. State and local communities can, and should, further expand their programs; however, economic factors must be given consideration in determining additional hospital needs. * * *

Facilities of medical schools should be expanded. Existing facilities should be utilized to the greatest extent possible to train more physicians, surgeons, dentists, nurses, technicians, and public health officers. Full cooperation of rural people with our established health units and existing health programs should be encouraged.

Greater emphasis should be placed upon preventive medicine.

In States where permissive legislation for the creation of public health units does not exist, State farm bureaus should seek the enactment of such legislation.

We favor voluntary plans providing medical, health, dental, and hospital insurance.

We urge a friendly attitude and fuller understanding on the part of the medical profession toward private prepaid medical insurance plans and the principles of their operation. Collection of maximum payments allowable under such plans, where in excess of customary charges, should be discouraged. We deplore practices of some in the

medical profession who take unfavorable advantage of the existence of voluntary health protection plans, increase cost of service under them, and tend to defeat their successful operation. Such practices tend to stimulate a demand for compulsory health insurance or similar socialized medicine proposals. We oppose any form of compulsory health insurance.

Then I also have a resolution adopted at the last annual meeting in November 1951, by the delegates of the county farm bureaus, which represent at our annual meeting all of the membership of the Farm Bureau in Missouri:

Rural Health

We are proud of the part the Farm Bureau has played in the field of rural health and urge Farm Bureau members to continue to support measures which will improve opportunities for healthful living in our State, aiding in the organization of county health councils, medical health units, and hospitals wherever such facilities are needed. We realize that not until more hospitals and other medical facilities are established in rural areas will enough doctors return to the country to practice.

We believe that our schools should carry a greater share of the responsibility of health education, both at elementary and secondary levels, and that health courses should be emphasized in teacher-training programs. We believe that services of the county health units should be available to teachers and school systems in their educational and correctional work.

We deplore the practice of a few members of the medical profession who take advantage of existing voluntary prepaid health insurance plans by keeping patients in hospitals longer than necessary. This practice tends to increase costs and destroy the effectiveness of such programs. It also tends to stimulate the demand for compulsory health insurance and socialized medicine.

We urge the early establishment of a state medical and nursing school. This school should be located where it will best serve rural Missouri and tie in with an expanded rural health program and insure the return of more doctors to rural areas.

To standardize the quality of milk to the consumer and eliminate duplication of inspection costs, we advocate a plan whereby milk inspection will be performed by State inspectors following a national code. The inspection of milk being a service to the public should not be a charge against the producer.

Raising Health Levels

As may be seen by the resolution of the American Farm Bureau Federation and that of our State Farm Bureau, the membership of the Farm Bureau—State and national—is definitely of the opinion that the increase in health standards, practices, and levels is largely a matter for self-help. From experience in Missouri, the members of the Farm Bureau are definitely of the opinion that

¹ Delivered at the Regional Hearing in St. Louis, Mo., September 15, 1952.

most health measures and advances must come from the people resident in any community, county, and State.

In a few cases where demonstrations may be of value, outside aid may be of advantage, but it is only through the exercise of individual responsibility that the health standard of any individual can be raised; it is only through the united effort of a farm family that the health level of the family can become higher; and it is only through united community work that the community's health can rise above that of the current level.

Hospital Facilities Adequate

According to the latest report of the Missouri Hospital Advisory Commission, at the present time the actual number of beds in use in approved general hospitals represented 82 percent of the total need in the State. With the completion and operation of presently planned and building projects, this percentage will increase to 90 percent. In general hospital needs in rural Missouri there are only two areas where reasonable adequate general hospital facilities are not available.

Physician Supply

The number of physicians for practice in rural Missouri is less than a generation ago. However, it must be recognized with better roads and automobiles, with generally accepted methods of office calls, with larger use of diagnostic and treatment methods in hospitals, there is no need of doctors in every crossroad in the State.

The doctor of today, with his improved means of diagnosis, with the many trained assistants, with much more immunization of people against certain infectious and contagious diseases, handles many more patients daily, weekly, and annually than his counterpart of 50 years ago. The recent trend of rural areas toward having only the older, less-ambitious practitioners seems to be reversing itself, and as more facilities are provided in rural areas, more and more young physicians are moving to rural areas.

State Medical School

The State has needed a State medical school for many years. This fact has been recognized by many but the question of location of the school has been hotly debated in the State. The last General Assembly set aside a sum to provide the start of a State medical school by the University

of Missouri, and the board of curators of this institution has definitely selected Columbia, the home of the university, as the location. Additional sums will be needed to provide the necessary teaching, hospital, and medical facilities. These will be provided by the State as needed.

Supply of Nurses

The supply of nurses, both for actual hospital need and for public health, is short. The principal reason for shortage of nurses is the low range of salaries that has recently been common. The recent increase in salary range will induce more young people to enroll in the nursing field. Undoubtedly, as the State School of Medicine progresses, a nursing school will be developed. There is an incipient movement for the training of nurses' aides, and the recognition of the value of such assistants is becoming widespread, and as a result the supply of these people will increase in the next few years.

Public Health

A survey some years ago disclosed that Missouri had no method of establishing permanent rural health departments or centers. The system used for many years had serious disadvantages and lacked permanency. The Farm Bureau undertook the work incidental to drafting a permanent system and enlisting the various other groups in the State interested in such improvement. The first act permitting the people of any county to vote for, establish a health center, and to manage and operate such, was approved by the General Assembly in 1947. The two basic factors in the act were to provide a special county tax for the operation of the health center and to lodge responsibility of management with the people of the county. At the present time, there are 16 county units so approved by the people of the counties with at least 12 more working toward the achievement of this goal.

The financial support required in some health activities should come in large part from the people interested. Expenditures of funds for better health in a community, county, or State, should be administered at the local level. None know local conditions and people as they, themselves, do. The management of local health centers must be in the hands of the local people; otherwise, waste of funds can be expected.

Preventive work, to be most successful, must have some local financing and responsibility. Curative work in the past has been extremely successful due to the efforts of the profession itself. This individual effort should never be jeopardized by any Federal encroachment or compulsory means to standardize the medical profession. The private relationship between doctor and patient should never be encroached upon.

Statement¹ of

DR. ALLEN STEWART

Regional Chairman and Member

Council on Rural Health

American Medical Association

Lubbock, Texas

How To Get Doctors for Rural Areas

I don't come up with any magic formula or any patent suggestion that can be applied to bring doctors to rural areas. It is a very complex problem. The problem of better medical service for rural areas has grown gradually more formidable because of very definite changes in our way of life in the past 25 years.

First, there has been a great migration of the population from farm to city. This trend has led to great concentration of people in cities and a marked thinning out of rural population. In other words, the trend has been toward centralization in population shifts.

With fewer workmen on farms and the development of many new inventions, the tendency has necessarily been toward greater mechanization of farm operations, toward larger acreage per worker and the consolidation of smaller farms into larger ones. Thus we see greater productivity per farm worker and more ground tilled.

Just as we have big business, we now have big farming, fewer small farms, sparser rural population, fewer tenant farmers, more dependence upon migrant farm workers paid by the day. Such conditions have aggravated the medical problem in many ways. For instance, there are fewer people to practice upon, but there is a relatively larger number of surgical casualties due to increased use of machinery.

Farm people—or rather, I should say, people on farms—have met these problems satisfactorily in some ways, notably in education. The one-room school house is gone. Now we have consolidated school districts, with improved buildings, and school buses to serve large areas. This method of attacking the problem should give patient and physician a clue to solving the problem of the decrease in the number of rural physicians. I shall refer more fully to this later.

Practice Moves to Cities

There have been changes in the medical scene in America, too. The concentration of large masses of people in the cities has naturally caused a great increase in the number of specialists, since specialists cannot flourish outside of densely populated centers. The attraction of the specialties to the medical student has aggravated the medical service problem, because we now have an increase in specialists and a corresponding decrease in the number of general practitioners.

Of course, to practice satisfactorily in rural communities a doctor should be a general practitioner. If there are fewer general practitioners, this will mean fewer doctors in rural areas.

The rural area today, being sparse in population offers less active practice to the doctor, even the general practitioner than heretofore, partly due to the situation mentioned before, but also directly due to another important fact. Twenty-five years ago the rural doctor could make a comfortable living making repeated calls for weeks on a typhoid fever case, treating summer diarrhea in children, or pneumonia with all its complications, whooping cough or scarlet fever, or watching a diabetic case gradually dry up and die.

With the advent of vaccines and sera and the wonder drugs, the prospects for extensive service and remuneration in a sparse population have decreased materially. Add to this one other important development, the automobile and the paved road. The rural physician is too often passed by and the patient driven to the city for treatment.

How has this problem been attacked? Farm people, seeing the benefits of consolidation of school districts, have carried the idea into the hospital field. Districts have been organized and hospitals constructed to serve large areas. The Hill-Burton Bill has been of great assistance here, but it is our conviction that more emphasis must

¹ Delivered at the Regional Hearing in Dallas, Tex., August 18, 1952.

be placed upon rural needs in the distribution of funds under the Hospital Construction Act.

Also, especially in Texas, where the Moffitt Bill authorized charters for cooperative hospitals in towns of 2,500 population or less, many hospitals have been constructed which attract young doctors to the area. The success of the cooperative organizations seems to be in direct proportion to the success of the hospital management. Where there is a good hospital superintendent to supervise service and watch costs, the whole venture usually succeeds; otherwise the contrary result is the outcome.

Community Counter Measures

In Kansas, due to the influence of Dr. Franklin Murphy, Dean of the medical school, communities have built and equipped offices and clinical facilities for doctors and have furnished living quarters. Such measures have been effective in influencing young general practitioners to settle in such communities. The facilities are leased by the doctor or sold on long term easy payments.

The efforts of farm people to better living conditions in their territory, to establish good schools and churches and places of wholesome entertainment cannot but have the effect of making themselves happier in their environment, as well as impressing young doctors with the idea that here is a good place to live and work and bring up a family.

The educational work of the extension services of our land grant colleges are a great factor in this movement. One of their efforts is in encouraging the formation of 4-H Clubs; one of the 4-H's is health. When good health habits are encouraged and health needs, both personal and public, are stressed there will always be a demand and a proper reception of a doctor. Moreover, who knows how many 4-H Club boys and girls may be attracted to study medicine and return home to practice?

Efforts by Medical Profession

Hand in hand with the work of the farm organizations has been the effort of the medical profession to improve the situation by bringing about a better distribution of medical personnel throughout rural America. Seven years ago the American Medical Association created a committee which met with leaders of farm organizations, to study the health needs of rural communities and to come up

with some answers to the problem. Since then, there has been an annual conference on the national level to discuss the various phases of the problem.

These conferences are attended by farm people, representatives of farm organizations, health educators, farm journal editors, extension workers, etc. Rural health councils have been organized which, in turn, have annual or more frequent meetings. Organization of district and local councils has been fostered. All such efforts have focused attack upon the rural health situation and are bringing results in many localities.

For many years the idea of giving scholarships to medical students with the proviso that they practice a certain time in rural communities has been suggested as a means to channel doctors to rural areas. The Commonwealth Fund was a pioneer in this movement.

The results have not been very conclusive. Many men having completed their training, have chosen to locate elsewhere and to pay back their scholarship loans. Some others have defaulted. It is hard to consider forcing fulfillment of a contract and requiring a man to work where his heart is not in it. The Mississippi State Legislature has appropriated a fund to be used for such scholarships. Other States and other organizations have adopted similar plans.

Two Objectives

All of this procedure will no doubt have some beneficial effect, but there are two objections.

First, the direction of the doctor toward rural medicine, and his conditioning for rural practice should start long before he enters medical school—in his home and community life, in his school, his church, his 4-H Club or his Boy Scout troop. It is often too late to impress him after he gets to medical school.

Second, it is not possible to coerce anybody to work where he is not happy. Furthermore, many having fulfilled their obligations as to service, or repayment, have promptly moved away afterward. This makes for too frequent turnover of doctors and poorer service.

To my mind, the greatest single advance to this movement for better rural medical service has been the organization of the National Academy of General Practitioners. This organization, with chapters in the various States has, in the few years of its inception, improved the position of the general practitioner, brought recognition of his

role from hospitals, stimulated his efforts for self-improvement, inaugurated a practical system of postgraduate training, all of which should presage better times ahead for rural medical service. Many medical schools now have special instructions for general practitioners in undergraduate and postgraduate levels.

Preceptorships for Budding Doctors

The American Academy of General Practitioners is responsible for the greatest step yet to bring the young doctor face to face with the rural situation. This plan requires the medical student in his senior year to live with and practice with a general practitioner, especially selected by the Academy, for a stated term, usually one trimester of 3 months. The student makes house calls, and hospital rounds with his preceptor, assists in deliveries or operations, works with him in his office—in short, practices medicine under supervision and becomes acquainted first-hand with the work and daily activities of the general practitioner.

Such a plan cannot but attract many budding M. D.'s to rural medical service. The enthusiastic institution of such plans in many State medical schools is evidence that it has struck a sympathetic note among medical educators. I am happy to say that this summer the preceptorship plan was started in one of our State medical schools and soon will be in operation in the other.

Conclusions: Better distribution of doctors in rural America will come about from active cooperation between farm people, farm organizations, and the medical fraternity.

Every effort which improves farm living conditions will attract more doctors to establish rural practices.

Educational efforts of health agent, extension workers, and medical general practitioners organizations will have a long range beneficial effect.

The best net results will come not from above down, but from below up. It should be far easier to keep doctors in rural areas if farm boys choose to study medicine. In other words, rural America may need some grafted stock, but it can rear its own doctors if it plays the game right.

Medical School Admittance

The CHAIRMAN. Dr. Stewart, is it a problem for rural young men to get admitted to medical schools? Sometimes the statement is made that

they may have this desire, but in competition, their being from rural areas, rather naturally excludes them.

Dr. STEWART. I couldn't answer that directly, Dr. Burket. Perhaps some of those who follow later might mention that, but my own impression is—no, that man is not discriminated against in any medical school because he is from a rural area.

I might say right here that in talking with one of the deans of one of our medical schools, I gathered that there is a rather false impression that a lot of men don't get into medical school. Perhaps some of them don't. There are many applications and many turned down, but very often a young man who wants to study medicine applies in about 10 different schools, hoping to get picked up by one of them. Iowa State University Medical School last year had places for 164 freshmen; they only had 168 applications. This dean I speak of said he was afraid we might have a shortage of doctors in the future. One of the reasons was that it looked like there was a trend among young men not to consider studying medicine.

Statement¹ of

MRS. MILDRED K. STOLTZ

Former Director of Education

Montana Farmers Union

Sunburst, Mont.

I want to call your attention to Montana, the third largest State in the Union, with only 4.1 persons, if you can divide a person into one-tenth, living on a square mile. We have approximately 600,000 people in the State. There are 147,000 square miles with many, many miles where no people live.

I would like to bring this down to my own area. For 19 years I traveled the State of Montana from corner to corner. I assure you that I am not boasting of that.

Now, if you are 50 to 75 miles away from a doctor, you doctor yourself—if you can—or if the accident is more than you can handle, you then put the patient, if he is not too badly off, in a car or pickup truck and take him to a doctor. If he lives he is worthy of his ancestors who homesteaded that great vast area.

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

You try poultices, you try everything under the sun. I am quite shocked to realize that I have the same attitude.

A week ago I ran both hands into a mangle . . . my knee was trigger happy, it was working, and I was too tired, and I forgot to let them out, so I hauled them out by main force. Now, my hands were kind of badly mutilated. . . . So I put them in cold water, then in hot water, then in cold water, and then in hot water, and I rubbed some salve on them and let it go at that.

26 Miles to Telephone

They have been pretty painful and it kind of shocked me to think that I did not even dream, it never even entered my mind, that I would drive to a doctor. Why? Twenty-six miles to a telephone, over roads that are almost impassable, if it rains, and absolutely impassable if it snows. Then if I got to a telephone 26 miles away I would then have to call in 45 miles away to see if the doctor happened to be there to take care of my hands. It just took too much time, and it never dawned upon me to do that.

Attitudes, then, are one of the things, one of the stumbling blocks, one of the real problems, and what you have never had, what your consciousness does not encompass, you can hardly visualize.

One out of every six in Montana, just one, has any service from the public health system we have in the United States. There are 75 percent, according to the figures in this little book, of the people of the United States who have some connection with public health service, but only one out of six of the people in our State. So what they have never had they do not know about.

It is not indifference, I assure you, because they are seeking and asking for some kind of help.

I do want to give credit to our present State Board of Health. They are doing everything possible. I want to give credit to our executive secretary of the State Board of Health, to the Federal Government, for the fine help that they have given us, but it is not enough.

It means, as I said before, a changing of the attitudes of the people.

Now, how do we go about doing that? Again I would like to bring it to you locally.

Since I wrote this paper and sent it in four or five days ago, one of my closest neighbors 10 miles away suffered a heart attack. At this time of the

year out in our country you are hauling wheat to town, and you haul wheat 45 miles each way, making a round trip of 90 miles. Well, we are in danger of frost and of losing our crops, so you work early and you work late, and you watch the weather with a weather eye. We have three eyes in Montana—the two eyes to see with, and the weather eye to feel what the weather is going to be.

Whether You Live or Die

Whether you live or die is contingent upon the weather.

So this neighbor of mine worked too hard and too long, and he did not feel well. When we don't feel well out there we say: "Well, it could be neuralgia or rheumatism, and I will work it out tomorrow."

So he kept on not feeling well. They took him to the doctor who happened to be at Shelby, Mont., the county seat town there, and the doctor there didn't know for sure what was the trouble, so they sent him, ironically enough, in the hearse, because we do not have an ambulance, and 12 miles out of Shelby he died.

Now, no one seemed to comment too much upon that . . . and that is the appalling thing, it is one of those things, it is the element of chance you take when you live in the wide open spaces without a telephone, without roads, and without public health services.

I imagine I have about a minute and a half left within which to try and present this picture. I have the same feeling now as when you take your car out in the winter time to try and get down the road 26 miles to a telephone and you know it is an impossibility. It would be impossible to bring to you the feeling that you have of frustration, and of helplessness in the rural areas without the average necessities that you need.

So I say to you that we must have many things. Other things have been mentioned here, and they are all necessary, but to me the one thing that we must have for these people to protect them, and to save their families, and to keep them when the doctor bill comes or hospital comes, we must have some type of Federal health insurance program that teaches health education, health needs, and all the things that can bring to the rural families of my State, all the things that can be brought to them through these programs. We need it very badly all the time.

Statement¹ of

DR. B. E. WASHBURN

County Health Officer

Rutherford County, N. C.

Conditions in One Typical Rural County

In discussing the health needs of the rural population of North Carolina, I shall tell you about such needs in Rutherford County, of which I am a resident.

This county, with an area of 544 square miles and 46,356 people, has conditions which are typical of those of the State at large. It is located in the western Piedmont section and consists of rolling hill country and mountains. The county is an important textile center, with 20 plants manufacturing products from cotton, wool, and other materials. But the greater area of the county is rural; 17,240 of the population, including 1,635 Negroes, lived on 3,540 farms at the time of the 1950 census.

Of the farm population, 4,500 were tenants. The average size of each farm was 63.4 acres and the main cash crops are cotton and corn. Some member of the family from 1,569 of these farms worked away from home part of each year to supplement the family's income, since the average value of the products sold (i. e., the cash income) from each farm was \$709.

Rutherford County Health Conditions

Medical and health conditions in Rutherford County are probably equal to the average of the State at large, but it is evident that with an annual cash income of only \$709 many rural families are not able to afford adequate medical care. There are 24 doctors resident in the county, of whom 6 give full-time service at the county hospital and 5 others do not engage in active practice; this leaves 13 general practitioners, with an average of more than 3,500 persons per doctor. And of the 13 in active practice, 11 live in towns located in 2 of the 14 townships near the center of the county.

Our county has had a hospital since 1906; this has recently been modernized and enlarged from 60 to 130 beds through cooperation with the North Carolina Medical Care Commission, and at present it adequately meets the needs of the county. There

is also an active health department, housed in a new and modernly equipped building, also obtained through cooperation with the Medical Care Commission. This health department has lent programs, especially for work in the schools.

Pupils are examined for physical defects before they enter school and at regular intervals afterwards. Parents of handicapped children are notified of the defects and urged to have them corrected. Treatment is provided for children from underprivileged families in tonsil, eye, and orthopedic clinics held at regular intervals; and maternal and infant welfare clinics are held weekly for the care of mothers and babies who are not financially able to afford a doctor. Also, venereal disease clinics are conducted weekly and fluoroscopic clinics monthly at the health center.

Care is taken to see that all babies, regardless of the financial status of the family, are immunized against whooping cough and diphtheria; and, in addition, smallpox vaccination is required before a child enters school. An important staff member is the health educator, whose duty is to coordinate the programs of the other health workers and the teachers, and to secure cooperation from parents.

Survey Shows Inadequate Medical Care

A survey of the health conditions of the county shows that in spite of the excellent hospital and active health department too large a percentage of the people receive inadequate medical care. Most of the industrial plants of the county have hospital insurance plans for their workers, but very few rural families have such insurance. The county welfare department provides medical care for sick persons on relief. However, there is a large group of families whose income is not sufficient to enable them to have their children treated for defects found in school examinations. Nor can they afford the cost of doctors and medical bills or hospital care for other members of the family.

Among this group are children with running ears, decayed and abscessed teeth, diseased tonsils and adenoids, defective vision, and other handicaps which retard them in their school work. And in this group are adults who suffer from chronic complaints: arthritis and rheumatism, defective vision, cancer and other malignant growths, deafness, diabetes, diseases of the heart and circulation, diseases of the nervous system, syphilis, and tuberculosis. These are all conditions which should have been detected and treated before they

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

became chronic and rendered the patient unable to do effective work.

Underlying Causes

The underlying causes of these conditions of health are:

1. Financial; family income is not sufficient to pay the cost of medical and hospital care.
2. There are not enough doctors and dentists.
3. Lack of education keeps many families from realizing the importance of keeping in good health.

The cost of medical and hospital care is high in comparison with the income of many of the farm families. The Rutherford County Medical Society recently published the following schedule of charges, effective February 1:

1. Penicillin by injection shall be a minimum of \$3 plus the office or home call.
2. Tetanus antitoxin injections shall be \$2 plus the office or home call.
3. House calls within city limits from 8 a. m. to 8 p. m. to be increased from \$4 to \$5; from 11 p. m. to 8 a. m. to be increased from \$5 to \$7. Country calls will be the same as city calls plus 50 cents per mile from city limits.

According to this schedule, a midnight visit to a home 10 miles in the country might amount to as much as \$15—\$7 for the call, \$5 for mileage, and an additional \$3 if the patient should need a dose of penicillin.

The scale of charges at the Rutherford Hospital is more moderate than in many hospitals of the State, being: "Ward charges (in 4-bed ward), \$7 per day; semiprivate room, \$8; private room without connecting bath, \$9; private room with connecting bath, \$10."

Handicap of Great Distances

Another factor influencing the cost of medical care is the small number of doctors practicing in the county, and the distances they must travel to reach rural families. And many patients are not able to pay for thorough examinations, especially if laboratory tests or X-rays are needed.

These conditions and the fact that the doctor is overworked probably lead to reports of cases in which symptoms are treated without much effort being made to locate the cause of the patient's complaint, and for so much treatment being in the form of a series of hypodermic injections, which are usually given by the doctor's nurse.

It should be said, however, that most country people like to get shots, and if they do not get

them, they do not think that they are getting modern treatment.

Still another result of these conditions is that it is rare for a person to go to his doctor for a physical examination, a procedure highly recommended by all health agencies.

Our county last year, or in the last year, however, has become much interested in community development. We have at present six strong communities that I know of which are organized and have improved their school facilities and social welfare work. It is hoped that we can get them also interested in health development, so much so that some of them may be able to provide a small hospital—such as Dr. Bond has told us about at Bat Cave, which is only across the border from our county in Henderson County—or a community health center, such as you have at Boiling Springs in Cleveland County, on our other side. If we can do that, it is hoped that we will be able to improve the health conditions of these farm families and of others.

Of course, another plan has been suggested by other authorities, such as improved hospital and health insurance. Also, turning out more doctors for general practice will certainly help. So I think that while conditions in Rutherford County are not favorable at present, we do have promise of correcting and improving conditions in the near future.

Measures Necessary

What can be done to change these conditions?

1. As to the lack of doctors, it is gratifying to learn that the medical schools of the State are now placing more emphasis on the training of general practitioners; and with the advent of the new school at the University more doctors will be trained than in the past. However, it will be difficult to convince young doctors of the need of their services as general practitioners, especially in rural districts, so long as the selection of students for admission to medical schools remains prejudicial to country boys; or so long as the system of teaching and hospital training glorifies the specialist.

At present, many students begin their medical study with the announced intention of becoming general practitioners and serving in rural communities. But, after 4 years of medical school and a period of hospital internship, most of them lose this vision of service, decide to specialize, and

finally locate in our larger towns where there are already too many specialists.

2. The financial aspect of the problem must be solved before a large group of rural families can have funds for medical emergencies, either when treated by the family doctor or in a hospital. An extension of hospital insurance to take care of medical and drug bills is necessary. Whether or not it should be underwritten by the State I do not know.

3. There should be clinics where physical examinations would be available to detect chronic diseases in their incipency. In a number of communities in other States and in Harnett County, N. C., clinics have been established which give 30-minute screening tests for as many as a dozen diseases at a time to apparently healthy persons.

The object is not to diagnose diseases, but to locate patients who have indications of chronic complaints; then if a more detailed medical examination might uncover a diseased condition, treatment can be started without delay. If a patient is being examined for one disease there is no reason why, at the same time, he cannot be examined for indications of several chronic ailments.

Clinics and Tests

It seems to me that this type of screening procedure could be conducted by the general practitioner. In his office he can check the patient's blood pressure and heart and examine him for signs of anemia, cancer, hernia, and tuberculosis; in his office laboratory he can test urine for sugar and determine the hemoglobin content of the blood. In addition, he can collect blood specimens and send them to the State Laboratory of Hygiene to be tested for syphilis, malaria, and diabetes. He can also have sputum tested for tuberculosis and feces for intestinal parasites. And when indications of these diseases are discovered the doctor can advise regarding treatment.

Much could be done to prevent chronic diseases if some department of the State University, or some other agency, would promote the multiple-screening idea in North Carolina. Clinics could be organized in villages and rural communities and the aid of the local doctors enlisted in carrying out such screening tests at regular periods when they would be performed at a moderate cost.

4. Finally, the people will have to be taught to take advantage of such clinics and tests, be willing to pay the charges, and to follow the doctor's advice as regards treatment, if such is needed. Effective education to convince the people that good health is essential to physical and financial welfare can be furthered by an increase in the number of health educators and an extension of their work in rural homes.

Statement ¹ of

DANIEL REED

**Michigan Farm Bureau
Lansing, Mich.**

Health Problem Considerations

I would like to qualify this presentation that we are making, not on the basis of health experts in the field, but simply as an expression of a group of farm people we represent. This group consists of 53,000 farm families in Michigan, who have given a great deal of consideration to this matter of health. These folks are organized in 61 county farm bureaus.

Within the 61 county farm bureaus are more than 1,150 community farm bureau discussion groups, meeting monthly to discuss topics of local, State, national, and international interest. The views we present in this testimony are the result of resolutions adopted by community farm bureaus, county farm bureaus, and the Michigan Farm Bureau.

These discussion groups have given a good deal of thought to health problems. Maybe the decisions reached are based somewhat on erroneous information. There may be additional facts needed, but the fact remains that this is the thinking of farm people as it has been accumulated through resolutions that have come down from county farm bureaus to the State Farm Bureau and incorporated in the State resolutions.

When we were getting ready to come down here, my associate and I went back through some of our resolutions for prior years to see how the Farm Bureau members had expressed themselves with respect to their interest in health matters. We took a typical year, 1947, and we searched through

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

the resolutions of that year and found that the health field was covered broadly.

As long ago as February 1919 the Michigan Farm Bureau indicated its interest in health affairs. Among the purposes included in its charter of organization is the statement that its objective was to provide ways and means for concerted action on agricultural problems. Through the years, resolutions of the organization have shown that problems of health, education, and other social interests were agricultural problems as much as economic considerations.

Health Resolutions

As an indication of the breadth of its interest, in 1947 the resolutions of the Michigan Farm Bureau pertaining to health covered a variety of subjects including:

1. A need for education on early cancer detection and for centers whereby this detection could be done.

2. Further study on the cause and treatment of polio. Farm Bureau people were urged to familiarize themselves with the work of their agencies which deal with the polio problem.

3. Local farm people were urged to participate actively in the organization and operation of County and Community Health Councils.

4. Rural people were urged to participate in the sponsorship of and attendance at the Michigan Rural Health Conferences.

5. The fertility of the soil has a definite relationship to the health of the people. Farm Bureau here urged a more active interest in the fertility of the soil through the conservation programs.

6. Not only are public dumps or places used by people for dumping rubbish along the highways unsightly but there is a definite relationship between the health of the community and the location and maintenance of garbage disposal dumps. Recognizing here this relationship, Farm Bureau was instrumental in securing the passage of legislation which would help to control the practice of dumping rubbish along the highways.

7. There was a recognition of the importance of the problem of sex degeneracy and legislative action was urged for coping with the problem.

8. We recognized that Brucellosis or Bang's Disease of farm animals is the cause of undulant fever in human beings and urged county boards of

supervisors and all agencies to support programs to eliminate or control this disease.

9. A desire to take part in the study of the conditions of migrant agricultural workers.

That gives you a broad idea. In that one year the Farm Bureau passed resolutions on those subjects.

In succeeding years, resolutions of Michigan Farm Bureau have expressed concern about the lack of doctors in rural areas and urged Michigan State Medical Society to assist in working out means to solve this problem so that the people of Michigan would have proper medical service available. We might point out that considerable progress has been made in this field and that many local communities have secured the services of a doctor through their own efforts in providing facilities through which he might effectively serve his community.

In 1950 delegates to the Michigan Farm Bureau Annual Convention recognized the need for extending the facilities of medical schools so that qualified students, regardless of race, creed, or color, might find an opportunity to train for service in the health field.

A specific farm health problem was pointed up in a resolution urging the development of a tractor seat to help prevent injuries to spine and internal organs of the operators. The increase in the number of these injuries has caused considerable concern.

Voluntary and Cooperative Efforts

Throughout its resolutions, Michigan Farm Bureau has pointed to the responsibility of people in the solution of these many problems of adequate health service. Farm Bureau members have said that the answer to these problems lies in voluntary and cooperative efforts of the medical profession, the hospitals, and citizens. Resolutions have constantly and consistently supported voluntary plans providing medical and hospital service.

We feel that the Blue Cross and Blue Shield plans have been of great value in providing Michigan citizens coverage, with 100,000 rural people covered in Michigan now by Blue Cross-Blue Shield through Farm Bureau alone—the best record in the United States.

Farm Bureau members asked for and obtained representation on the Michigan Hospital Service Board.

We have called attention to the fact that much of the responsibility for the successful operation of these plans depends upon the medical profession itself. We have discouraged collection of maximum payments allowable under such plans wherever they are in excess of customary charges.

We deplore the practice of some people in the medical and hospital professions who take unfavorable advantage of the existence of these plans and thus increase the cost of service under them, tending to defeat their successful operation. Such unethical practices can only lead to controls and regimentation in the medical professions.

Physical and Economic Health

Vital to the health of America is an economically sound agriculture. Only when farmers are able to maintain and improve the fertility of their soil can our Nation hope to be well nourished. Thin, starved, minerally inadequate soils produce food incapable of supporting good nutritional standards. Our resolutions have continually pointed to the need for adequate returns from farm sales to enable farm operators to maintain their lands in a good state of fertility.

It has been recognized that the Nation's economic health is not separated from its physical health. Farm Bureau members in Michigan have frequently pointed to the need for a sound economic structure if our Nation and its citizens are to be in a position to do for themselves those things in the health field which can contribute most toward the maintenance of a good physical America.

Specifically, Farm Bureau members have felt that our best interests in the health field can be served with a minimum of governmental interference. Extreme cases can be cited to point up extreme conditions. Our Farm Bureau resolutions point out that we should strive for the best health service for the greatest possible number of people. We cherish the intimate relationship between the individual citizen and the private physician of his own choice and recognize that encouragement of initiative on the part of members of the medical profession in the service of their patients is important.

We hope that this expression from the 53,000 Farm Bureau families in Michigan will be of assistance in the study of the health needs of the Nation.

Address¹ of

D. W. WATKINS

Director

South Carolina Agriculture Extension Service

The rural population of South Carolina makes up 63.3 percent of the total population. Over one-third of the entire population of South Carolina is in the age group under 15 years of age. Between 1940 and 1950 the number of children under 5 years of age increased 32.7 percent, and the number of persons over 65 years of age increased 41.4 percent.

Accidents occur at a higher rate among rural people than in the city. Rural incomes are lower than city incomes, and low incomes are associated with higher illness rates. There is a maldistribution of medical personnel, and hospital and diagnostic facilities which affects health services in rural areas. Most of the pediatricians are located in the cities while 60 percent of all the children live in places of less than 10,000 population. The shortage of dentists is even more acute than of physicians, and the shortage applies to nurses, laboratory technicians, and other health workers.

Progress in health education is being made with the guidance of public agencies and private organizations. Progress seems to be proportionate to the effective educational work done.

A half-century ago in South Carolina mosquitoes of the anopheles species were common enough to take an enormous toll through the resultant malaria. Health, achievement, and life itself, were sacrificed to this disease before effective programs of eradication of the mosquito were understood and applied by the people.

Routine immunization against common contagious and infectious diseases such as smallpox, diphtheria, tetanus, and typhoid is paying dividends in the form of a better life in my State the same as in other States.

Pellagra, a common disease 25 years ago, today is much rarer since people understand its relation to the diet and how it can be prevented by proper nutrition.

The State Department of Health disseminates public health information, and through County Health Departments, it promotes a State-wide health education program. . . .

¹ Delivered at Regional Hearing, Raleigh, N. C., August 25, 1952.

The Health Department also looks after water pollution problems, sanitary engineering, maternal and child health, crippled children, laboratory testing and services, dental education, and water fluoridation. It helps treat and control tuberculosis, cancer, heart disease, venereal disease, and various communicable diseases, including rabies. . . .

A State health specialist with the Home Demonstration Branch of the Extension Service keeps the home agents up to date . . . trained for health education work. The Home Demonstration Clubs, made up mainly of farm women, have been very influential and effective in matters of health. They sponsored health clinics in the early days until now these are often well organized and conducted in a routine fashion especially in the schools.

Health Education Campaigns

They organized drives or campaigns to educate the people on many health problems. . . . They have promoted better sanitation in the handling of food products, including milk, meat, locally prepared corn meal, and with water sanitation on public grounds as well as at the homes of the people. They have enlisted the help of technical persons . . . to train leaders for better home care of the sick and for child training in health measures.

County Agents Assist

Health matters are assisted in a great many ways by county agents, men and women. I quote a little news release on . . . the result of a survey by one of our Negro agricultural agents in Laurens County, S. C.:

Agent Holcombe reported 114 farm families were visited, of which 17 owned their land and 97 were nonland-owners. Among the facts disclosed by his report were that 38 had no screens; 37 were completely screened; 39 were partly screened; 15 had no toilets; 77 had makeshift toilets; 1, a septic tank; 20, a sanitary toilet; 27, improper water supply; 84, properly covered wells; 40, proper livestock sanitation; 30, improper; 48, good over-all cleanliness; 36, fair; 28, poor; 62, adequate supply of milk; 42, inadequate; 42, none; 57 had adequate gardens; 50, inadequate; 11, none; 50 had adequate eggs; 47, inadequate; 9 had none; 60 had adequate meat supplies; 35, inadequate; 19, none.

Agent Holcombe said: "The object of the campaign and the health education program was to bring up the living standards of Negro farm families and to improve life among them."

Mind you, these data I quoted were all relating to farm Negro families.

Farm and home extension specialists and agents have done a great job over the years in teaching better farm living with respect to housing, clothing, and nutrition. They are now cooperating with State and county committees of livestock producers and with other public agencies in brucellosis eradication among livestock and its counterpart, undulant fever, among people. We know that nutrition is perhaps the most important environmental factor affecting the health of an individual.

A Better Planned Diet

Extension workers in agriculture and home economics have helped to organize and have cooperated in much progress in matters of human nutrition. The changes in food habits to conform to better diet patterns have been a major activity, and this activity has been supported by those who work on farm production problems.

A better planned diet of home grown products means better rural health than many people formerly had. More lean meat, eggs, milk, green and yellow vegetables and fruits in the diets of people of this area has long been a need which, through educational work to bring about changes in food, is now better understood and better supplied.

To mention one specific project, let me remind you that South Carolina traditionally consumes a lot of cornbread and corn grits, which like any other good thing, can be overdone. To offset the food deficits of corn, the State has a law requiring all corn meal and grits to be enriched with the needed vitamins and minerals—including a special grade of limestone and tri-calcium phosphate as a source of calcium, plus niacin, thiamine, riboflavin, and iron. This material is prepared for the mills by Clemson College on a nonprofit basis. Clemson also has invented, and offers for sale, an attachment for corn mills which automatically feeds the enrichment materials into the meal and grits as it goes through the mill.

In addition, a corn-cleaning attachment has been developed and is offered to corn mills for precleaning shelled corn for human use. The great problem in the small corn mills is to turn out a sanitary product without rodent excreta and insect content. The cleaning equipment helps. However, much educational work is also necessary on harvesting, storing, fumigating and moisture

control of corn intended for food and such work is under way with some progress beginning to show.

... Health is the most valuable possession next to life itself. If we have health we are too likely to take it for granted and not protect it. To avoid losing it, or in an effort to regain it, we pay more for the protective foods, for medicines, for doctors' services and for hospitalization than for most other desirable things in life.

Health education is still deficient as long as a comet with a meaningless name like Had-a-col, can streak across our health sky collecting millions from the ignorant to go into the pockets of the wrong people. The health of all the people is of concern to every man, woman and child, and it even transcends the right of groups or individuals to special privileges or prerogatives. The health of all the people is a great complex problem. Certainly its solution requires more education and economic opportunity for the mass of people. Yes, we are improving in these respects, but we still have far to go.

Statement¹ of

DR. W. S. RANKIN

Raleigh, N. C.

I should like to discuss the subject, "How Can We Best Meet the Needs of Indigent and Medically Indigent in Rural Areas?"

Now, the general problem of medical care is a major problem by any standards of comparison, but it is a major problem among major problems. It includes the problem of more even distribution of physicians, more adequate nursing supply, and more adequate and better distribution of hospital beds. In addition, it includes the question of the means for meeting some of these very important problems, the medical insurance, the prepayment of medical care, and finally the problem of the medically indigent or the indigent. I do not think that a modification is necessary.

It seems to me that the problem of the indigent in medicine presents a more human and direct appeal to the heart than any of the other problems and no less a challenge to the head than other problems. We are dealing here with people who are dependent upon groups like those represented here and dependent upon us for their health and their lives.

I might say a few words in regard to the general outline of the problem of indigency in medicine and the recent changes that have taken place.

There was a survey by the United States Bureau of the Census of hospitals in 1923. In 3,100 hospitals, general and special, they found at that time that 36 percent of all the days of care were furnished to those who were indigent. That was some ten years before the Duke Endowment came into the medical field in the Carolinas.

In 1927 we found in the general hospitals of North and South Carolina a 43.1 percent rate of indigency. In 1932, that percentage reached the top—60 percent. It has been coming down rather steadily since then and is now around 15 percent.

That sounds pretty good. The percentage has come down to 15 percent from, we will say, somewhere around 33 percent or 35 percent for the country as a whole in 1925. That looks like a real gain. It is, in a way, because that 15 percent of indigency stands in spite of the expanded hospital facilities that have developed in the last 25 years; there is twice the number of "free" days of care in the general hospitals in these two States than there was 25 years ago.

In other words, instead of 311,000 general hospital days of care for indigent patients in 1927, there is something like 650,000 now, although the percentage is only 15 percent. The reason the percentage is lower is that indigency has increased twofold with the expanded hospital facilities, whereas the days that are paid for have increased eightfold. That explains the drop in the percentage.

I hope that we have some suggestions, and rather definite suggestions, with respect to the remedies for this very important problem.

Statement¹ of

MRS. W. K. CUYLER

Health Chairman

North Carolina Federation of

Home Demonstration Clubs

Durham, North Carolina

How Organized Farm Women Are Helping to Improve Hospital, Medical and Health Services for Rural People

The Extension Service, through its own sponsored organizations and called meetings of rural

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

¹ Delivered at Regional Hearing, Raleigh, N. C., August 25, 1952.

peoples, emphasizes what individuals can do for themselves to attain higher health levels. This is accomplished through the 1,848 Home Demonstration Clubs for women, farm organizations for women, and 4-H Clubs for boys and girls who are 135,000 strong.

Health problems have been attacked through the teachings and aid of the Extension Service, sponsored groups in general, and Home Demonstration Clubs in particular. . . . Important among them are immunization and other preventive measures; fire and accident hazards; better housing, diets and improved foods and food supply—for instance, the corn meal enrichment program that has been started in many counties; prevention and control of tuberculosis; polio, cancer, and, last but not least, suggestions have been offered for handling the common cold, and Home Demonstration Club members have been active in helping the tuberculosis and cancer units, and also the bloodmobile.

The Federation of Home Demonstration Clubs in North Carolina . . . has a membership of almost 48,000 women, just about half of the rural women in North Carolina, . . . wishes to emphasize that in order to be of greater help to the rural population, additional means and methods must be made available for reaching the thousands of individuals who are not touched directly by the organization. All rural inhabitants must become intelligently aware of existing health services and facilities available to them, not only before they can take advantage of them, but before they can act in cooperation with others to secure needed benefits which are not yet available to the individual or the community.

It is emphasized further that it has been found that when the rural peoples are educated in the possibilities of better health programs, they themselves wish to act in order to attain results rather than to expect services to be made available through other than their own efforts.

COOPERATIVES: COMMUNITY ACTION TO IMPROVE HEALTH

Statement ¹ of

MRS. RALPH MOYER

Community Health Association

Two Harbors, Minn.

The Effect of Consumer Organization on Medical Services

The community health center of Two Harbors is a medical cooperative. In conjunction with the Community Health Association it has served our rural industrial community of 5,000 population for almost 8 years, having begun operations on November 1, 1944.

The Community Health Association, comprised of 1,358 families, including 3,800 individuals, contracts for the services of physicians, and, with Community Health Center, for hospital care of association members.

Community Health Center operates a 33-bed hospital, providing general in-patient hospital facilities, plus well equipped out-patient diagnostic facilities such as laboratory, X-ray, fluoroscopy, physio-therapy, electro-cardiogram, and basal metabolism. Each member has one vote in determining the affairs of the organization. The

governing bodies are composed of nine directors, three of whom are elected each year to serve a 3-year term.

All decisions regarding medical treatment and medical treatment and medical purchases of drugs, et cetera, are regarded as beyond the jurisdiction of this lay body, and are in the sole control of the doctors.

Hospital Benefits

Hospital benefits provided include: Ward bed accommodations—up to 90 days per year on any continuous illness; unlimited use—when ordered by a physician—of operating room, laboratory, X-ray, drugs and all other hospital facilities without additional charge, except \$1 per film for X-rays taken. Charge is made for blood plasma. Complete maternity benefits are provided after 10 months membership for a \$4 per diem charge.

All medical, surgical, and obstetrical services, as are within the ability of the staff physicians, are provided, and special arrangements are made by the association to cover members for pediatrics, EENT, gynecological, urological, dermatological, and certain orthopedic and surgical referrals.

These include services in the hospital, clinic offices, and in the home. There are no maximum or minimum limits. The only charge is \$2 for

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 15, 1952.

the first home visit in any illness; otherwise all charges for service are completely covered by the monthly membership fee.

In addition, our doctors work with the public health nurse in providing medical care for outlying lumber camps on a monthly clinic basis.

The cost for this service for a family of three or more is \$6.75 per month.

Limitations

Now, these are the things that we cannot do:

Certain aspects of surgery are not covered. These include surgery of brain or nervous system, cosmetic surgery, orthopedic deformity, and surgery of lungs, heart, and intrathoracic organs.

Drugs, except as administered in the hospital, are not covered. Mental illness and chronic illnesses, which require more than ninety days hospitalization, are not provided.

These limitations are, in large part, economic ones. It would not be feasible for a small group in a small town to try to incorporate all of the rare and costly aspects of medical and surgical care and to distribute the costs equitably.

But we are also limited through inability to secure enough doctors to make our plan function to its true potential. Not until the future physician in medical school and internship is inculcated with some degree of self-reliance, not until he is acquainted with the problems of general practice, and is provided with a modicum of laboratory facilities and can be guaranteed some time off for further study and vacation, in actual practice, will enough able men go into rural general practice.

This is, of course, not our problem alone, as earlier speakers have proved. Any rural community is faced with the same difficulty, largely because our medical schools and internships have all but given up the training of general practitioners. Their emphasis on the importance of various specialties, and their reliance on the intricate laboratory and other diagnostic procedures, have made their graduates hesitant to set up practice beyond the immediate reaches of an elaborately equipped medical center.

Physicians for Rural Practice

The modern doctor is trained exceptionally well in the handling of hospitalized patients, while 90 percent of a rural general practitioner's work is with out-patients.

Part of our problem, in procuring doctors, how-

ever, is unique with us. We have, in the past, had qualified surgeons and internists on our staff. They have left, expressing as at least part of their reason for going, their membership rejection in the local medical society. Each of these men was qualified in his field and had, in his former locality, been a member of good standing in that county's medical society.

Right now we are finding it next to impossible to get specialists, although we have had many who were interested in the plan and anxious to become part of the group, because they fear the results of such ostracism from the society.

The three general practitioners who now comprise the staff find this condition burdensome, also.

They receive, as part of their contract with the association, two weeks of study leave each year. Yet, one of the best and one of the closest centers for graduate study, Chicago's Cook County Hospital, where many valuable short courses are given each year, will not accept doctors who are not members of their local medical societies.

Grade A Medical School Graduates

Pertinent to the discussion is the fact that all three are graduates of so-called Grade A medical schools—one from the University of Minnesota, and two from the Jefferson Medical College in Philadelphia.

All three have likewise met requirements for and received Minnesota state medical licenses. Yet the implication is that our doctors are somehow unfit for membership in this august body, and unfortunately, this implication is accepted by the antiooperative segment of the community.

State licensing requirements in Minnesota have also contributed to our difficulties. The basic science examinations present, it would seem from the failure statistics, an abnormal stumbling block, and their rather arbitrary ruling concerning graduates of foreign medical schools has cost us at least one genuinely interested surgeon, whose post-graduate training and residencies have all been in United States hospitals, and who is now a licensed physician in a midwestern state.

But to come to Minnesota he would have to serve a year's internship in a Minnesota hospital.

Certain of our problems then, would seem to be geographic rather than medical, and perhaps a nationwide examination in licensing procedure, such as Canada has found satisfactory, would help to solve these, at least.

Hospital Problems, Too

Our hospital, too, provides a problem. It is an old frame structure, long regarded as a fire hazard, despite our efforts to meet interim fire precaution requirements. To provide adequate hospital bed requirements for a community of this size will require an expenditure of at least half a million dollars. Without some help from government sources, under some such bill as Hill-Burton, we will be unable to construct a suitable hospital—and ours is scheduled to be closed as a fire trap on October 1st.

Despite its quota of problems, we think our plan provides better medicine for more people in our community than they received before its inception or than they would be likely to receive in event of the cooperative's collapse.

There are now four doctors in the community, three in our plan, as compared with a total of two before the cooperative medical group began practice. The town has had the attention of specialists—and can have them again—who would otherwise have been unlikely to choose so small a community for practice.

The group practice of our physicians makes for better cooperation and easier consultation—all of benefit to patients.

And the prepayment plan, which works a minimum economic hardship on the members, most of whom are regularly employed, the majority on the railroad and/or docks, insures better health for the community through preventive medical measures, which might otherwise prove too costly for the ordinary consumer.

Commissioner SHEAHAN. Have you applied to Hill-Burton?

Mrs. MOYER. No, we have not, because one of the stipulations, I believe, in Hill-Burton, is that you provide approximately one-half, is it not, through the communities, and we, because of this medical society difficulty, are having a little trouble getting the community completely behind the hospital.

Statement ¹ of

MRS. HARRY J. PETERSON

Executive Secretary

Minnesota Association of Cooperatives

St. Paul, Minn.

Now, there are three reasons why citizens of

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 15, 1952.

rural Minnesota are not receiving proper medical care:

One, shortage of medical personnel and facilities.

Two, no source of financing to help provide necessary facilities, for day to day medical care in doctor's office or in rural clinics.

Three, legal restrictions against voluntary cooperative efforts to provide adequate medical care.

The services of the country doctor in modern medicine are as much of the past as is the use of the Kentucky rifle in modern warfare. The science and practice of medicine has become specialized. Doctors of medicine want to associate their specialties to provide complete service.

The business structure of such practice is a clinic. Operation of a clinic makes necessary a center of population large enough to make efficient use of the staff of doctors. Everyone knows and will agree that there has been a mass exodus of doctors from rural areas to the cities. No one can or should be critical of the doctor because he wants to specialize or because the larger centers of population provide better earning possibilities. However, this does create a problem for rural areas because it vitally diminishes the availability of medical care.

I have heard it argued that the great improvement in transportation has made it possible for people even from isolated areas to drive by automobile to secure medical care in larger centers. We would indeed be in greater difficulty were it not for the automobile. There is, however, a limit to travel even by automobile for people who are ill or in need of emergency care.

Fewer Doctors in Rural Areas

These better transportation facilities in a way have added to the problem by increasing the patient load. Fewer doctors in the more distant rural areas are being called upon to serve a larger number of people. It is impractical and impossible for all the people to go to the Twin Cities, Rochester, or Duluth for medical care. Outside of those three centers the ratio of doctors to population is deplorable in many areas, particularly in the northern part of the State. In the wealthier southern part of Minnesota, people are perhaps more able to pay the asking price for medical care, and of course there are more doctors in the area for that reason.

At this point I wish to place in the record information to substantiate my statement with respect to the lack of adequate medical care in rural Minnesota.

Doctors Overworked

In Clearwater County there is a population of 10,158 according to census figures. There are two doctors in the county, one in Bagley and one in Clearbrook. At one time there were three doctors, but the third doctor didn't survive for some reason or other. Traditionally there are two doctors. One doctor for 5,000 people. The doctors are badly overworked. The nearest town with anything approaching adequate medical facilities is Bemidji, a distance of 40 miles from Clearbrook and 28 miles from Bagley. If we accept Bemidji as the medical center for the surrounding counties the picture looks something like this:

In Beltrami, Cass, Clearwater, and Hubbard Counties there is a total of 33 doctors. Twenty-one of the thirty-three doctors are in Bemidji. This means that in an area of approximately 5,000 square miles, the medical services available to rural people are limited to what can be provided by the more or less isolated practitioner usually working with limited facilities. The ratio of doctors to population in the area is 1 to 2,300.

In Aitkin County the problem is even more acute. There are only six doctors in the entire county. All of them reside in the town of Aitkin. The ratio of doctors to population is 1 to 2,400. Aitkin County covers 2,100 square miles and has only one trading center of any size, namely the town of Aitkin. There is not much freedom of choice of doctors for the people in either of the areas in the examples cited.

Farm People Send Delegation

Five years ago a delegation of farm people from this and similar areas of the State came to St. Paul to tell the State Legislature about this situation. Most of them reported that their doctors were badly overworked, and that this and other conditions cause doctors to move away from such areas, thus aggravating a situation that is already bad.

One witness said: "Our doctor often goes 2 or 3 days without having his shoes off."

Another said: "Our child was born 8 years ago and the doctor was too busy to come."

Another witness said that because of great dis-

tances to the nearest hospitals, babies are often born on the way.

Nearly all testified that they needed legislation that would allow them to set up prepayment funds with the power to engage doctors and provide modern facilities. This legislation has been denied to them by our State Legislature.

Great Rural Need Unmet

There is no satisfactory source of financial aid available to help provide facilities. The Hill-Burton Act provided money to build hospitals. To be sure, it was helpful to some communities but most communities were unable to meet the standards required for hospital construction under the act. Some communities were of the opinion that if they could secure a hospital the medical care problem would be solved. They found instead that their problems were only beginning. For example, the town of Bagley in Clearwater County now has a hospital. There is the expense of running the hospital and there still are only two doctors in the county. There is a nice building in which to be ill but no more medical attention than before.

The great need of the average rural community has not been met, namely, the means whereby doctors may be engaged to serve the needs of the community under conditions which meet the requirements of modern medicine.

Costs Offset Benefits

There is presently no agency, public or private, from which finances for these purposes may be had. To really do the job will require long-term Government finance similar to the aid which electrified the farms of America. Such plans will need to have the protection of strong and effective laws against discriminatory and conspiratorial activities by which organized medicine seeks to deprive such plans of doctors and in other ways seeks to destroy them.

There are those who feel that the solution to this problem lies in insurance, either of the commercial accident and health type, or the Blue Cross—Blue Shield type. The farm people of Minnesota have been using insurance for more than a decade to prepay their hospital and medical expenses, and during that time the situation has not improved. Many of us believe that it has grown steadily worse. For instance the benefits derived from insurance coverage have been more than offset by

increased cost for hospital service and medical care. If any plan is to be of permanent good it must provide some means to prevent costs from completely offsetting benefits to the member.

At the same time, we have had enough experience to know that it is possible to use the prepayment principle in an organization to gather funds to improve the quality of medical services, the amount of such services, and the variety of specialist skills available in rural communities.

Cooperative Plan Pools Needs

This has been done in the rural community of Two Harbors, Minn., where the people are now served by three doctors on the staff of the cooperative Two Harbors Community Hospital and Health Center, and one doctor in private practice. In addition, various specialist services are brought to the community from other centers. Before they organized their prepayment fund, the people had the services of two doctors in private practice, or again the familiar ratio of 1 doctor to 2,500 people.

The cooperative plan provides an organization through which the people pay for their medical services in advance, on a fixed monthly or quarterly basis, provide the facilities and equipment needed by doctors, and engage doctors to care for the members of the prepayment fund. The basis of compensation for the doctors is subject to mutual agreement, but fundamentally, it is dependent upon the number of persons the doctor serves.

This plan allows a rural community to arrange for needed specialists to come to the community on a part time basis. It allows many communities to pool their needs for both general practitioners and specialists. It permits communities too small to support a doctor to arrange for his services a few days a week.

Our experience and observation convinces us that this plan would grow very rapidly if it were not for certain legal difficulties.

In Minnesota, as in most other States, we lack an enabling act under which such a plan can be incorporated. Our State officials have taken the position that a plan incorporated for such purposes as have been described above would be guilty of the corporate practice of medicine. In so ruling, they have ignored the fact that in such a plan there is no third-party interest between the doctor and the patient since the plan is made up of those who would use the service.

As a result, plans now operating have to function on an unincorporated membership basis, with the serious disadvantage of unlimited liability for the individual member.

Opposition of Organized Medicine

We have a further obstacle, in meeting the medical needs of rural Minnesota, in the bitter opposition of organized medicine. Organized medicine's political power has been used to block enabling legislation. The boycott, by the medical societies, of doctors serving such plans has made it difficult to get enough doctors, since a doctor who is barred from membership in the medical society is also barred from certain rights and privileges which are almost essential to his professional career.

Legislatively, we need both an enabling act and a code which will protect a sound and ethical prepayment plan from this type of boycott and other unfair practices.

Recommendations

We recommend to this Commission that:

1. Americans should be given an opportunity to solve their own medical care problems through voluntary action.
2. That encouragement, guidance and assistance should be provided by the Federal Government to fulfill this purpose.
3. That among the items of assistance to this program Congress should make available financial assistance in the form of long-term loans to be used to finance facilities and to assist the plan in its early stages of operation.
4. That in certain areas it may be necessary to provide grants in aid to keep a plan solvent in its initial stages of operation, especially where protection has been provided to poor risks for justifiable purposes, but we do recommend that the people who receive the benefits should be required to finance as much of their own program as possible.

Statement¹ of

MR. CHARLES BANNISTER

**Representing the Arrowhead
Health Association
Duluth, Minnesota**

The Arrowhead Health Association was organized in 1948 to provide prepaid medical care to the

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 15, 1952.

people of Duluth. Capital was raised by the sale of memberships and arrangements were made with a group of doctors practicing as the Arrowhead Clinic to provide the needed services in return for an agreed-upon monthly prepayment.

It was originally intended to operate a hospital in connection with the plan, but experience proved that the capital requirements of such a plan were too great without more outside help than was available.

We have also had difficulty in maintaining a proper medical staff partly because of the attitude of the local medical society. But we have made progress on this problem, and are now providing a comprehensive coverage for 7,500 persons to whom such care is not otherwise available.

Service Valued

An example of how this type of service is valued by the beneficiaries is afforded by my union, Local 84 of the Hotel and Restaurant Employees. We have Arrowhead service through a welfare fund. Recently the members were given an opportunity to choose between this service and other available forms of prepayment. They voted 10 to 1 in favor of Arrowhead.

The income of these people averages around \$1,800 a year. They know that they are getting medical services of far greater value than they could afford to buy on a fee basis.

For some it has meant the difference between life and death, as in the case of one member 80 years of age whose wife has become an invalid, and who is unable to work. This service has pulled him through two sieges of pneumonia.

In another case a bellman died at the age of 23 of diabetes after medical and hospital services of \$4,400. The prepayment medical services, plus the insurance provided by the welfare fund, covered the expenses which otherwise would have fallen upon his parents, persons of moderate income.

Statement¹ of

OSCAR D. BERG

Farmer

Milaca, Minn.

Until the dairy farmers of Minnesota began organizing health groups around their local cooperative creameries, our farm people had no way of automatically prepaying their hospital and medical expenses on a group basis, the way industrial employees have been doing for years.

But 10 years of experience in this field has produced some very important results. We offer our creamery patrons automatic payment of sickness expense premiums through deduction from their cream check accounts.

Plan Brings Results

First, our farm people have become accustomed to budgeting more and paying more for medical care, and they are getting much more medical service of a better quality than ever before. The very fact that they have been budgeting in a prepayment plan has made more medical care available to them.

Second, the availability of more medical care has improved the situation with regard to disabling accidents and illnesses by getting more and better service more promptly in an emergency.

Third, we have developed organization among the people of the communities so that we can have an effect as consumers on the future development of services.

I am a member of the Bock Cooperative Creamery in Mille Lacs County. This is one of several counties in Minnesota where all of the cooperative creameries offer their patrons this protection, insured through Group Health Mutual.

As a member of Group Health Mutual, which has a scheme of democratic membership control, I have been elected to the board of directors to represent the district in which my creamery is located.

Value of Insurance Appreciated

Ten years ago when we began this program, our people were not financially or psychologically able to pay premiums high enough to provide adequate care, or care of the quality they are now getting. It is safe to say that they did not realize what was meant by adequate care, unless they had been through the tragedy of too little care too late in their own immediate families. In these 10 years they have learned not only to pay for more care than they had previously been getting, but to want more than they are now getting.

We recognize that the insurance method of prepaying for medical care has its limitations, but nevertheless it has done some valuable services for our farm people.

For one thing it has relieved many a family of the responsibility in case of crises of deciding be-

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 15, 1952.

tween financial ruin and possible permanent injury to a loved one.

I give you the example of a young farmer in our health group. His wife developed serious complications in childbirth and was rushed to Minneapolis for the special attention that the larger hospitals can give, and a Caesarian operation by a Minneapolis specialist. The mother came through without injury, and so did the baby, with the help of oxygen and incubator.

When the bills were counted up the case came to nearly \$1,000—which for a young fellow just starting out would have been ruinous. As it was, most of the expense was covered by insurance. Most important, this method of prepaying meant that there was no cause for hesitation or doubt whatever when the emergency arose.

Advantage of Consumer Organization

Accidents of a serious nature are more common among farm people than among any other occupational group in this part of the country, and they, too, can be ruinously costly. I have just seen a recent list of accident benefits paid by our organization for farm accidents where the bills ranged from \$173 to \$1,902, and the benefits from \$156 to \$545. This shows both the advantages and the limitations of insurance.

Our organization is working with our local health groups toward a form of service that will cover the needs of the members more comprehensively and pay larger portions of the expense through the prepayment method.

A primary advantage of consumer organization in this field is that we can go forward with new and more satisfactory methods of prepaying the costs and providing the services, even though these new methods might mean shifting at least part of our operations from insurance to some other form.

Statement¹ of

MR. J. K. KYLE

Executive Secretary

Wisconsin Association of Cooperatives

Madison, Wisconsin

In discussing what Wisconsin is doing to meet the rural health problems, I have divided the material briefly into three subtitles: one, our need; two, the steps which have been taken; and three, the additional steps, which, in my opinion, need to be taken to provide adequate health services.

1. Needs

First of all as to the needs:

We, like some of the States that have been represented so far, have a situation where there is a scarcity of both doctors and health centers in the smaller rural communities.

I do not have a complete list of them, but I do want to cite as typical examples three communities, most of them with a population in the village itself of about 1,000, with surrounding rural territory to be served.

I have here the August 1st issue of the Grant County Independent. Our situation in Grant County is not quite as bad as Grant County, Minnesota, but we have had a serious situation there. I want to read a couple of paragraphs to illustrate that problem.

The first is a headline from Potosi, which is the name of the community:

For the third time in less than a year the people of this area are without a resident physician. Dr. Vernon E. Spitznable, who opened his medical office in the village early in April, left us to return to his position with the Milwaukee City Health Department.

Potosi area residents have been without continuous medical service since W. J. Kelley left in October of 1951 to accept a position with the University of Colorado.

In January, arrangements were made to have Dr. Phillip Welton of Oconomowoc, recently discharged from the Armed Forces, move to Potosi. Doctor Welton left after several weeks because of illness.

I might add that there has been full cooperation on the part of the county and State medical societies to bring medical service to this community in the interim.

Other parts of the article explain how part time doctors have been made available. There have been similar experiences that I know of in Palmyra, a village of comparable size, which now happens to have a doctor at the present time, and in Fairchild where again there is a doctor at the present time, but where the situation was so desperate a couple of years ago that the townspeople were contemplating bringing in a displaced person from Europe, and had some argument with the State Board of Medical Examiners as to the licensing of that individual.

Small Health Center Needed

Another thing that we need, and this has been testified to by Dr. Souci, who has been chairman

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

of our rural health conferences for the past two years, is a small health center or clinic. Doctor Souci has provided that need in a small city of about 2,000 or 2,500 where he practices, where he has individually been in a position to set up that type of small clinic.

However, there are many communities that do not have people. First, they have no doctors, and in other cases there are no people with the financial means and the ability to look forward as Dr. Souci can.

Lastly, we, of course, have done very little in developing comprehensive health service beyond the insurance programs in developing our keep-well programs.

2. Communities Adopt Subsidy Plan

Now, the few steps that we have taken. Some communities have adopted the subsidy plan. They have bought houses for doctors. They have furnished offices for doctors. Generally, this has not been too satisfactory. It leaves things up in the air, and it does not do anything to establish the permanent keep-well program.

Enabling Act for Hospital and Medical Service

In 1947, in Wisconsin we passed an enabling act to allow people to build up hospital and medical service by the mutual aid principle, through the use of cooperative health centers. These are now authorized under our State law.

But it has now been a little over three years since that act was passed and, unfortunately, there has not been as much use made of it as we would like to see. There have been two small hospitals organized, both of them in rural areas, and both of them filling a need. There are others in the process of organization. But this program has, necessarily, been slow.

3. Additional Steps

We feel that this program might be greatly speeded up by use of what is known as the REA financing principle, in other words, loan aid for these mutual aid activities from the Federal government.

We in Wisconsin are rather proud of our record in using this type of Federal aid without any great burden on the Federal treasury. It has been used for some 25 years now in the farm credit field. Farm loans produce credit loans, and our State is one of two which now has a record of having paid back to the Federal government all the money which was loaned to our production credit associations to set up farm credits for our people.

We have used it extensively in the REA field. Those loans are not all paid yet, but they are being paid regularly, and many of our associations have paid a little bit in advance.

We believe that this principle could be used to bring the small health centers and clinics to the rural communities. We believe that it could be used to supplement what is being done under the Hill-Burton Act in providing hospital service, where people want to get together and provide that service for themselves, and we believe, furthermore, that it will do much to do what the insurance plans have not done so far. They have been all right as far as they have gone. They have spread the cost of hospital and medical service, but they have not provided that keep-well program.

There should be regular examinations by doctors. These, we feel, are so necessary in bringing up the standard of our rural health. We feel that if we could have from Washington some angle along the REA financing line, we could do something about the comprehensive keep-well service that is so necessary.

CHILDREN AND THEIR HEALTH: A NATION'S CONCERN

Statement¹ of

DR. MAX SEHAM

Pediatrician, Minneapolis, Minn.

I am glad to have the opportunity to speak to you on behalf of the elementary and high school children. I represent no organization or group officially. I make my plea in their behalf as a citizen, and as a practicing physician, who has

devoted himself to the health and welfare of children for more than 40 years.

Now, I agree with my colleague, Dr. Kennedy, that the United States is one of the healthiest Nations in the world, and that Minnesota is one of the healthiest States in the country.

I am equally proud, with my other colleagues, of

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

the great advancements that have been made by the medical profession, and by American medicine.

I realize that the opportunity for survival of the average American child is much greater than it was 25 years ago; that the infant mortality rates have decreased very markedly. But if we stop there and present only the rosy side of the health picture, I think that we are presenting an incomplete and not an entirely true picture.

It is for that reason that I would like to present the red side of the ledger. I would like to show the unmet needs. I would like to give you facts and figures which show that we have a long way to go before we can sit down and be complacent and say that all is right with the world.

Now, I know that statistics are distasteful, especially if they show us to be in the red, but if we are to act intelligently and objectively, we must know how many children are afflicted—with what mental and physical defects—and why.

Now, the figures that I shall present are from the Children's Bureau and the survey of the American Academy of Pediatrics.

According to the Children's Bureau, in 1950 there were over 20 million children of this age group who were undiagnosed and untreated, and in the time at my disposal I can merely mention some of the most common of these diseases and defects which have the greatest social and economic significance.

Six Million Crippled Children

There are 6 million crippled children who are unable to lead normal lives. A majority of these children could have escaped many serious consequences if prompt and effective treatment had been within their reach.

Anyone who has had the care of these children knows that most families cannot afford the high cost of specialized care, and only through mobile units operating under a State program through Federal aid can this large group of children be reached and given the needed help.

The last three national epidemics of polio have increased considerably our crippled children's population. The cost of bringing a polio victim to maximum recovery is a staggering expense, even to a well-to-do family. It is a financial impossibility for most families.

Rheumatic Fever and Tuberculosis

There are 500,000 children suffering from rheumatic fever and its serious complication—heart

disease. This is a major cause of death in this age group because of the tendency to recurrence; and because the disease strikes about 20 times as frequently among the lower economic level group as among the middle classes prevention and treatment must be accomplished on a mass scale.

On his own, the private doctor does not have the necessary laboratory and institutional facilities necessary for complete treatment, nor are the few voluntary and special clinics more than a drop in the bucket.

Although we have made great progress in the conquest of T. B. there still remain 175,000 children and teenagers with active T. B., with only a fighting chance for survival.

The old idea that race and geography are the predisposing factors has been discarded. It is now agreed by the best authorities that contact and exposure are the chief dangers. The death rate is highest in those States, and among those families, who have the lowest purchasing power.

The disease is three times as frequent among Negroes, Indians, and Spanish-American as among white children. In the South the death rate is three times as high among the Negro children as among the whites. But in Minneapolis, where organized efforts have been made for over 30 years through mass detection and equal accessibility to treatment, the Negro's chance of escaping death from T. B. is much higher than that of the Negroes in the South.

If we would do for all the children of the land what we do for some, we could soon eliminate this White Plague as a No. 1 threat to the health of our Nation.

Visual and Hearing Defects

Four million children have some form of visual defect. Fifteen thousand are totally blind, and 15,000 are partially blind. Add to this number those who have refractive errors and we have one child in every five under 21 years of age who needs glasses or some form of medical treatment to restore them to normal vision.

Of the one million children with known impaired hearing, about 17,000 are completely deaf. Most permanent damage to hearing is largely the result of neglect. Qualified physicians using antibiotics can prevent a high percentage of ear damage, yet only 10 States today are engaged in the program for diagnoses and treatment of ear defects.

Dental decay, as you have heard from Dr. Jordan, is another major health problem. It is estimated that the rate of development of cavities is five times as great as the number filled. Between 75 and 90 percent of all school children have dental defects and caries.

Emotional Disorders in Children

Another serious problem, which only recently has aroused the people, is the countless number of children with psychosomatic and emotional disorders. We know that one child out of 20 can expect to spend some part of his or her life in a mental hospital or sanatorium.

With all the skills we have developed in the area of child guidance, only 25 of our States have any sort of child guidance clinics.

Why, in view of these undisputable facts, do we permit so much unnecessary human misery and suffering to continue? We have the know-how and the financial resources to solve this vital problem. What, then, are the bottlenecks which prevent us from fulfilling our obligations to our children?

At the risk of oversimplifying the solution to such a complex and gigantic problem, I think the most important reason for failure is, first, the lack of and unequitable distribution of mental hospitals; two, the prohibitive cost of medical care for too many families; and three, the inadequacy of medical inspection in schools.

System of Medical Inspection

There is no need to enlarge upon the first two factors, but I would like to say something about the system of medical inspection.

To quote ex-Surgeon General Thomas Parran:

There has been almost no progress during the last 25 years in the decrease of physical defects among school children.

What health benefits are the children getting from the 30 millions we are spending annually on medical inspection? One out of every 15 children attending public schools gets so-called medical examinations, which are really a medical inspection. Half the counties have no school health services at all, and in the other half where medical inspection has been established, the service is limited to detection and first aid.

Making Health Services Available for All Children

Now, we must admit that the parents alone, with the help of their private doctors, and voluntary

health programs, cannot cope with this complicated and far-reaching situation.

I do not advocate that the Federal government should remove from the parents their prime responsibility for the medical care of their own children. But if it is impossible under the present system of American medicine for all children, whatever race, color, habitus or economic level, to secure the highest quality of preventive care, then it is the obligation of society to make available such services through tax supported programs, either Federal or State, which the local community demands. This is especially necessary in the rural districts where there are no health departments and no private voluntary agencies; and also in areas where children of minority groups live.

As a private practitioner, who depends upon private practice for a livelihood, I have no fear that such a program will tamper with the present status of "rugged individualism" in the practice of medicine; nor need it deprive the parents of their choice of private physicians, nor lower the income of the physicians. It would merely make accessible to those children who, through no fault of their own, need but do not get the preventive and curative services which the wisest and richest parents give to their children.

Statement¹ of

SAM RABINOVITZ

Executive Secretary

Michigan Youth Commission

Detroit, Mich.

First in priority is the need for all kinds of personnel caring for the physical and mental health needs of children. Although Dr. Fritz Redl of the Michigan Youth Commission will say more about this in his personal presentation, it is emphasized here because of its seriousness and urgency. Certainly, so far as personnel for voluntary and official agencies is concerned, there exists a serious shortage all the way from the hospital and institutional attendant to the top rung professions. This shortage extends to practically all children's programs including teaching, child care, etc.

Treatment Facilities

A second urgent need is that for treatment facilities—hospital and clinic—for children who are

¹ Delivered at Regional Hearing at Detroit, Mich., September 23, 1952.

mentally ill. A treatment hospital constructed on a cottage plan near Detroit and adequately staffed to care for many young people now backed up in detention homes, training schools, institutions for delinquent and other "cold storage arrangements" could become a reality with the speedy completion of architect's plans and presentation of all facts to the 1935 State legislature.

Community child guidance clinics, under joint community—State operation, have demonstrated their preventive and treatment worth and have received public acceptance; they should be doubled in number as soon as funds and staff are available. There is also the urgent need for small treatment homes for mentally disturbed children; these should be planned in conjunction with regional detention facilities for children awaiting juvenile court disposition.

Finally, expansion is needed in community educational opportunities and State hospitals for our mentally retarded children. The urgency of these needs is reemphasized and underscored in recent studies by the Joint Legislative Committee to study foster care; Governor's Study Commission on the Deviated Sex Offenders; National Probation and Parole Association (for the Michigan Probate Judges' Association) on detention of children in Michigan, and the several reports to the Joint Legislative Committee on Reorganization of State Government.

Community Health Departments

The Youth Commission recognizes that our local health departments provide essential, basic educational, preventive and follow-up health services for mothers and children. Prematurity still ranks as one of the most important causes of infant deaths in Michigan. The commission strongly feels that "basic to the establishment of comprehensive programs for care of mother and child is the availability of those many services offered by well-developed, modern health departments, staffed by full-time competently trained professional personnel serving a reasonable unit of population." Unfortunately, many vacancies exist at present in established health departments and many inadequately prepared personnel are employed for lack of available qualified applicants.

Our commission believes that our school health services have to be expanded and integrated into these full-time community health departments, with more attention directed towards parent and teacher education, and productive follow-up on health examinations when given. The importance of this approach is borne out when we find that 20 percent of Michigan school children have vision defects; 3 percent of Michigan children have significant hearing losses; and the correction of dental defects of the average Michigan child who has been found to have 2.1 primary and 5.9 permanent teeth attacked by caries, will require twice as much dental time for the average 9-year-old as that needed by the 5-year-old.

The Youth Commission, therefore, recommends that our established health departments should be strengthened and that single and multicounty departments should be established as soon as possible to serve the 13 counties so served at present.

Existing Conditions Dramatically Revealed

Field visits by members of the Governor's Migrant Commission and representatives of agencies and organizations cooperating, reveal existing conditions in a dramatic way.

The cabin . . . houses a family of 6 . . . This cabin was reported as one of the better ones . . . It was screened and the basic structure was in good repair. A wooden, movable toilet was located outside . . . directly against the rear wall. There were no bathing or washing facilities present. Water for cooking, washing and bathing had to be transported from a farm house approximately one-eighth of a mile away.

The second visit was to a cabin . . . occupied by three men . . . The screen on the door was practically demolished and the screen door itself was broken. It was evident that this condition existed before the present inhabitants arrived. The same was true of the outside toilet which had a broken seat and could be considered suitable by our minimum standards only because it was not being used. The pump, not far from the toilet, did not function. We spent about 15 minutes helping the inhabitants in an effort to get it to work . . . There were no bathing or washing facilities.

The cabin was in fairly good condition. There was a good pump with good water. There was even an iron drum which served as a garbage container.

The final visit was made to a group of migrants from Texas . . . They had received numerous advances of money from the company . . . they were being well treated by the company, the storekeepers and the citizens of the community. Their housing was good . . . Only children of 14 years of age or over worked in the

fields . . . Both adults and youngsters seemed happy, well-housed and well-adjusted.

The Migrant Worker's Health

The following types of serious health problems are reported by representatives of the State Department of Health:

The tuberculosis rate amongst migrants from Texas in this area is at least 10 times as high as among Michigan residents. Although Mexicans comprise 1 percent of Saginaw county population, during the crop season they occupied 26 percent of the beds in the Saginaw County Hospital. A new health problem may develop this year among the Mexican Nationals because they are screened in Mexico rather than at the reception center by the Public Health Service.

A cooperative plan between the sugar beet companies and the State Department of Health to give physical examinations to migrant workers was discontinued because it might be construed to be discriminatory. A plan which worked successfully for 4 or 5 years whereby a fluoroscopic examination was given in Texas before the worker was allowed to come to Michigan was discontinued during World War II and has not been reinstated.

It should be reemphasized that progress has been made in certain areas in improving the sanitary conditions and health services of migrant families through the efforts of a large number of individual employers and growers' associations, communities and voluntary organizations, especially religious groups. The assumption of these responsibilities on the local community and State levels should be encouraged. However, migrant agricultural workers and their families move across county, State and national lines. Some of the health problems they present will have to be tackled by States working together, and the Nation as a whole, with guidance and leadership from the Federal Government.

And finally, we believe that all State laws which affect the physical and mental health of children and families should be studied with the view to their revision to remove duplication of responsibility, insure more effective services and extend some services to large numbers of children with special health problems; i. e., crippled children, blindness and deafness, heart disease, epilepsy, cerebral palsy, and so forth.

Statement¹ of

MR. VAUGHAN BLANCHARD

Divisional Director

Health and Physical Education

Detroit Public Schools

Detroit, Mich.

I shall present to you what I feel are 10 needs of children to improve their health conditions.

1. There is a wealth of health information available today. It comes through newspapers, magazines, radio, and television. Some of it is accurate and scientific, some is partially true, and some is definitely vicious and misleading.

There is an evident need for determining how such information may best be screened and utilized and how basic scientific health information as supplied by the schools may combat inaccuracies frequently broadcast to the public.

Unfortunately school systems do not have the funds to sugar coat health as many of the commercial agencies do.

2. Having determined the best utilization of available health information and having translated this into acceptable knowledge to be attained by the school child, there is a crying need for transferring this knowledge into action. The majority of school children are imbued with health knowledge. Their attitudes and habits in this area of learning leave much to be desired.

3. Closely allied to the utilization of scientific health knowledge is the need for closer cooperation between the school and the home in applying such knowledge to home and community living. This is strikingly evident when, through the school health service program remedial physical defects are discovered but corrections are not secured. Failure to secure these is altogether too frequently due to apathetic parents.

Teachers Trained in Health Teaching

4. Parents are not entirely to blame in the failure to get the school and the home closer together in health knowledge, attitudes, and habits. Schools need teachers who are better trained in health teaching and more adept at translating everyday living into healthful living.

Furthermore, teachers need more time in an already over-crowded curriculum to teach basic health precepts and to establish closer and more understanding relationships with the home.

¹ Delivered at Regional Hearing, Detroit, Mich., September 23, 1952.

Unquestionably teachers in classroom situations are graded on their ability to teach certain subjects in the curriculum. When we ask them to undertake the teaching of health, teaching of safety, teaching of character, it is very difficult because they just do not have the time for some of these things if they are going to continue to do a job in teaching the three Rs.

School Nurses

5. As badly as better trained teachers are needed, school nurses are needed more. The training of the latter is adequate, but there are too few of them. School nurses as a general rule do a splendid job as liaison persons between the school and the home. There are pitifully few of them to do the job adequately. The health of school children and of preschool children could be greatly improved were there enough school nurses to make more home contacts and to work longer and hence more effectively both in the school and in the home.

6. With better trained teachers, more nurses, and closer rapport between school and home there is also need for closer relationship between the school and health agencies in the community. This applies to professional, semiprofessional, and non-professional health agencies alike. Too frequently, each of these gets up on a horse and rides off in all directions. Well organized community health councils with comprehensive representation in the membership can go a long way toward meeting this need—the need that everyone in the community work together harmoniously for the physical, mental, and social health need of boys and girls.

Better Health Records

7. As an outgrowth of such improved relationships there might well come better health records of individual children. These are needed as well as a standardized health examination form. It is quite possible now that a parent may be requested to have his son examined by a physician when he enters school in the fall, again when he joins the YMCA, when he wishes to join the ROTC, when he joins a Boy Scout troop, and before going to summer camp. Too frequently, each organization has its own health record form and will not accept that of another. Standardization, or at least reciprocal agreements, are needed for greater efficiency.

8. Regardless of how well the foregoing needs may be met, they are dependent for ultimate suc-

cess on certain others. Vast improvements have been made in providing healthful school surroundings in new schools. There are still large numbers of old schools which do not practice the health rules which they preach, due to inadequate lighting, poor acoustics, improper seating, and outmoded lavatory and toilet facilities, to name but a few.

In many communities also even though new and modern school buildings are erected as fast as funds will allow, too frequently they become overcrowded in a relatively short time. Such overcrowding results in a curtailment of the health program.

Dental Health Education

9. And since dental caries is one of the most serious health problems among school children, not only is an adequate dental health educational program in the schools necessary, but also reasonable assurance that there are enough dentists in the community who will treat children in their dental chairs.

10. And lastly, in spite of increased clinic facilities in many communities, and in spite of the willingness of physicians to examine and treat school children at reasonable cost, there are many difficulties in securing proper care of the semiindigent and indigent in the available clinics. More are needed if we are to give school children the service that their bill of rights proclaims for them.

Dr. BABCOCK. Are there any questions?

* * * * *

Standard Health Form

Commissioner RUSSEL V. LEE. Mr. Blanchard, I am greatly taken with this idea of yours of having a standard health form for a child. I can conceive of something that would hold his immunization records, and so forth, and follow him through his school and college life.

Do you know if that has been done anywhere? Has such a form been prepared?

Have you one?

Mr. BLANCHARD. No.

Commissioner LEE. Are there any?

Mr. BLANCHARD. Not that I know of. We have tried to get agencies together in this community to develop a standardized form but many of those agencies I mentioned are governed nationally and subject to their national form.

Commissioner LEE. That is something that

would simplify the draft very greatly if such a form were really used.

Dr. BABCOCK. Thank you, Mr. Blanchard.

* * * * *

Obtaining Medical Personnel

Commissioner WALTER REUTHER. May I have one question?

It has been pointed out here by speakers representing the medical profession that we have an adequate supply of doctors and dentists and all the other people necessary to meet our health needs. You have pointed out that the school children are sadly neglected with respect to dental and medical care.

What, in your opinion, is the major obstacle in our inability to get the people who know how to perform this service together with the people who need it as relates to school children?

Mr. BLANCHARD. I do not know whether I can answer that. I would say that we have a little difficulty in getting adequate numbers of physicians in our program. We do have a great deal of difficulty in getting an adequate number of dentists to take care of childhood dentistry.

Whether the lack of dentists is due to a lack of interest in that profession, whether it is due to the fact that dental colleges refuse to take but a very limited number into their profession, I do not know. But I do know the need exists.

Statement¹ of

DR. FRANK VAN SCHOICK

**Michigan Academy of Pediatrics
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In a recent communication from Dr. Albert Heustis, Director of the Michigan Department of Health, it was stated that through the school health program approximately one-half million school children over a 5-year period were given vision screen tests. More than 20 percent of these were found to have visual defects.

Most of these are congenital, the shape of the eye, defects over which we have no control.

Of this number more than half were not aware of their defects and were in need of medical attention.

Hearing studies made on a similar number of children revealed 3 out of every 100 children so

examined to have hearing losses and in need of medical attention.

Dental surveys in school children have been conducted in many communities and have likewise indicated the need for greater attention to this phase of health.

Research Improvements

Research in medical and social problems has created better tools and techniques to use in the fight against disease. These have had a profound effect in the battle against disease and death.

The development of immunizing substances establishes a protection against contagious diseases.

Better knowledge of food preservation and preparation together with improved sanitation, has helped to reduce the incidence of diarrhea and vomiting in infants.

The development of better incubators and the knowledge of their use have aided in the reduction of loss of life in the premature.

Improved obstetrical methods and their judicious application have reduced maternal and infant mortality.

The discovery of new drugs and antibiotics has provided a tool with which to combat many of the infections.

Better understanding of the physiological and chemical needs of the body has helped immensely in the treatment of disease.

The above-mentioned improvements are only a few of the many discoveries by research which have played such an important role in making a better place for our children to live.

Disease Prevention

Economically, it is cheaper to keep one's house or car in good repair than to let either become worn out before calling the repair man or the mechanic for a complete rehabilitation. To most parents the same principle can be applied to the cost of keeping their children healthy. From the above statistics it is evident that sickness from certain of the communicable diseases has been practically eliminated by immunization procedures.

Following the advice of the physician in prescribing the correct foods and methods of preparing foods for infants has reduced not only the frequency of deaths from gastrointestinal disease, but also the frequency with which the disease occurs, and prevented the need for extensive medical and hospital care for treatment. Earlier recognition

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

on the part of parents, and earlier diagnosis and institution of treatment by the physician of diseases, such as measles, whooping cough, pneumonia, and others, shorten the course of such diseases, or make it possible to prevent their spread to others in the family or community, thereby reducing medical costs not only to the family but to the neighborhood as well.

The majority of the medical professions, and pediatricians in particular, are much interested in the prevention of disease. By this means not only better health standards have and will be attained, but the cost of medical and hospital care for the individual family and community has been and should continue to be reduced.

Medical Costs Rise

Unfortunately, costs for medical care in many families have not been reduced but on the contrary may have increased. Parents of the very small, prematurely born infant who now may survive, the congenitally malformed, or of children afflicted with such diseases as poliomyelitis, rheumatic fever, tuberculosis, or other diseases of a chronic nature requiring long periods of hospitalization and medical attention, realize only too well that the financial responsibilities are unbearable.

Medical fees are but a small fraction of the total costs under these circumstances. Fortunately, county and State governments, through the Michigan Crippled and Afflicted Children's Commission, other public and private funds and insurance programs, have shared in the expense of giving medical care to these children.

Child Care Needs

A recent survey of child health services in the United States was made by the American Academy of Pediatrics with the cooperation of the United States Public Health Service and the United States Children's Bureau. The result of this survey has been published. The study made clear that to provide better child care there are two major needs:

1. Better training for all doctors who provide child care.
2. Better distribution of services for child care.

According to replies from doctors to a questionnaire sent to them as part of the survey, nearly half of the general practitioners had had virtually no hospital training in child care, and nearly one-fourth of the pediatricians replied they had had little hospital training in the medical care and

health supervision of children. They had to learn the hard way after entering practice.

Complete medical care is not available to all children. Those living in metropolitan and adjacent areas were found to receive 50 percent more care than those in isolated rural communities. The number of physicians in the larger cities far outnumber those in rural communities per 1,000 population.

The survey also revealed that more than one-third of our children were cared for in hospitals that were inadequately staffed and equipped for the care of children. Preventive medical programs were shown to be lagging in rural areas and deficiencies in dental care were particularly noticeable in these communities.

Statement¹ of

DR. OLIVER E. BYRD

**Director, Department of Hygiene
Stanford University
Stanford, Calif.**

I think in approaching this problem of school health needs that there are two fundamental concepts that the Commission ought to keep in mind. The first of these is that the school exists as a major social institution for the basic purpose of education. If we strip all of the other functions away from the schools except one I think we would leave teaching as their single responsibility.

The second major concept that we must keep in mind, I believe, is that there is an intimate relationship between health and learning. In other words, it has been the experience of practically every classroom teacher to encounter in her class pupils who have handicapped hearing, who have handicaps of vision, or who are ill with some chronic sickness; and as a consequence of that illness that child is denied, or at least it is more difficult to educate that child up to the level that would otherwise be possible.

Therefore there is a definite association between the health problems in any community and learning. In other words, education does have a relationship to this problem.

With those two concepts in mind let me sketch for you quickly what a major school health program consists of. There are seven major parts. I am only going to discuss the part that is applicable

¹ Delivered at Regional Hearing, San Francisco, Calif., September 29, 1952.

to this particular situation, but I will run over the others quickly.

School Health Program

First, there are what is called the public health services. These include all the specialized medical, dental, psychiatric services, including those of the school nurse.

Second, there is the health instruction program. This includes the development of the school curriculum—what the classroom teacher arranges in terms of what the child can learn about health.

A third part of the school program is safety. This encompasses the organization of the school safety patrol, fire safety as required by the State Department of Education Code, and instruction in many other aspects, including traffic safety. As you know, in the high schools driver training is voluntary, but driver education is a safety requirement. And there are many other aspects of the safety problem that the schools are giving a great deal of attention to.

Fourth, there is the nutrition program. This includes the school lunchroom. The schools operate under the National Lunch Act that Congress passed several years ago, which concerns the provision of food and which also provides that attention be given in the school curriculum to the matter of nutrition.

The fifth part is the physical education program. I am not going into that, except to say that there are many intimate relationships involved. To name just one: Suppose a child returns to school following an attack of rheumatic fever. Every physician advises at least considerable caution before that child is injected back into a vigorous program of physical education. And this matter has many, many other aspects.

Then I believe mental hygiene is the sixth part. The mental hygiene part of the program includes the arrangement of learning experiences under what I think can best be described as a favorable emotional atmosphere in the classroom. We have plenty of research that demonstrates that learning takes place best if there is a good feeling between the teacher and the child. As you know, that boils down to mental hygiene.

The seventh part of the school health program is sanitation in the environment. This includes the quality of the plumbing that exists in the school, the ventilation, the illumination, and the accident hazards, and any other factors in the

school environment that may be hazardous to health.

Provision of Health Services

Of these seven major parts of the school health program I think the one that is most applicable today is that which pertains to the provision of health services; in other words, the use of the doctor, the nurse, the dentist and other specialized personnel, in cooperation with the schools.

To begin with there is a tremendous shortage of school physicians. You can look at this problem in two ways: First, you can approach it from the standpoint that the schools should have school doctors, to be paid out of school funds perhaps, and who devote 100 percent of their time to school health problems of children. That is one way of looking at it.

Full Utilization of Physicians

The other way is that the schools should not employ physicians but should cooperate in the fullest utilization of physicians in the community.

Now, if you accept the first viewpoint, then there is a tremendous shortage of school doctors. For example, in the city of Los Angeles there are seven vacant positions in that one community, seven opportunities for doctors to be employed by the Board of Education. The Board of Education cannot fill those positions because physicians generally are trained for the treatment of illness; and I think they rightfully have in mind the private practice of medicine. Or let's put it this way: They have received so little introduction in the field of school health that they are not interested in the field in terms of making a career of it, with certain exceptions.

So from that standpoint there is a tremendous shortage of medical personnel in the schools. But from the other point of view, the schools have no greater shortage than does the general population, and therefore I think the schools cannot make the particular complaint about the shortage of physicians in that regard.

The School Nurse

As for nursing, there is also a shortage there. One of the problems, as you know, in the field of both public health and school health is obtaining the employment or services of a school nurse. We don't have enough research to give you standards or recommended standards in terms of the proper load per employed nurse.

Industries have made investigations—for example, General Motors made one and concluded that for every 800 workers they should employ one industrial nurse, and that when they had 801 workers they should employ a second industrial nurse. They calculated that on the basis of dollars and cents. It was profitable to them to provide that service.

The schools have not done sufficient research on this problem. We can't say we need a school nurse for every 1,500 pupils. In Sweden they have a standard of one school nurse for every 1,800 pupils by law. But actually that is based partly upon guesswork.

We do need in this area greater cooperation between the medical personnel and the organized health groups with respect to the schools. We have a great deal of that cooperation, the present trend being that the public health department and the school health department utilize both groups in a school education program.

Education: Cheapest Preventive Measure

Let me say that in terms of the many problems that have been mentioned today, such as accident prevention and diseases, education is one of the cheapest preventive measures we have. Many times it is more important than the availability of clinical facilities.

One illustration: Suppose a person has cancer. If that person does not understand the early symptoms of cancer, or if he has not been convinced that he should report to a physician for early care, then he does not seek the attention that may achieve for him a complete cure. In that case, you see, the medical facilities are less of significance to him than his being educated in the significance of these personal problems. So education has a tremendous relationship to the whole thing. At least that is my viewpoint.

To summarize, then, I think that the relationship between the school and health needs is first, we do not have enough nurses or doctors working directly in the schools. There is a great shortage.

Second, the schools themselves have neglected their opportunity in the field of health from the standpoint of education, which is strictly prevention. That deficiency can be traced back to the fear on the part of the teacher training institutions to do the proper job of training the school educator, administrator, and teacher. That deficiency is being rectified at the present time in

part. I think there is a greater need for cooperation, and that has brought certain problems with it.

Physical Examination for Work Certificate

Commissioner ELIZABETH S. MAGEE. I would like to ask whether your boards of education have responsibility for physical examination of young people going to work; and if so, whether the examinations are handled by private physicians or by school physicians? That is, is it established whether they (young people) are physically able to take a certain kind of job?

Dr. BYRD. That is a question that we can answer yes or no, because in some communities the schools have arranged for periodic medical examinations. They have the personnel to do it, to examine all of the children in the school. Therefore, that would include the group that you are asking about. However, that is the minority. Only 7 percent of the school districts throughout the United States have employed school physicians.

The great majority, then, are getting school examinations of children by private practitioners on some type of personal cooperative arrangement.

Incidentally, a study in Chicago has shown that education is just as important as having all of these resources available for the correction of defects and handicaps. Now, I don't know the exact number, but I will say the parents of 50 percent out of a group of 1,500 children in whom defects had been discovered by school health examinations had not obtained the recommended corrections when a follow-up study was made. And the investigation was of sufficient magnitude to discover that the reason they hadn't gotten these corrections was because they had not been educated sufficiently to the seriousness of the problem.

Commissioner MAGEE. But you say the minority have regular examinations. What happens in the districts where they don't have regular examinations and the children are getting certificates to go to work?

Dr. BYRD. There are really two answers to that. One of the plans in operation concerning school health, known as the Astoria Plan, does not call for regular examinations, and still it achieves very good results. In that plan children must have an examination when they first enter school. Thereafter they will have no further school health examination unless the teacher and the nurse in joint conference on each child at least once a year, recommend that a further investigation of the child's health be made.

A study showed that 80 percent of the school children don't need periodic or regular health examinations. About 20 percent may need them more frequently. So the answer to your question is that I cannot give you an explicit answer. I would say that in some cases examinations are made of youngsters for health permits that certify they are ready to go to work, but in a great majority of cases I would say no examinations are made.

Commissioner MAGEE. It is not required by law?

Dr. BYRD. So far as I know, it is not, but I may be ignorant as to that.

Dr. SHEPARD. Dr. Bert Thomas, medical director of the State Department of Employment, might be able to elaborate on that question. Dr. Thomas, do the physical examinations work permits come under your department?

Dr. THOMAS. I don't quite get the question, Doctor, because we have no work permits whatsoever. Ours is merely a program of disability examinations, paying benefits to those unable to perform their regular and customary work. I don't think that ties in with this, but is a more specific question.

Statement¹ by

PAUL E. LANDIS

Supervisor

**Health, Physical Education
Columbus, Ohio**

The presentation which I am making today represents the educational viewpoint concerning the health needs of the Nation.

Good health is the birthright of every child. No one is adequately prepared for effective living unless he has a well-functioning body and can make reasonably successful adjustments to life's situations. Both are essential for achieving happiness, personal efficiency, and the attainment of life's goals. Good health helps one to live a useful and well-adjusted life necessary for successful social and family living. It aids in personality development, contributes to vocational success, and helps to equip one for wise use of leisure time. It gives strength, builds morale, and promotes resistance to disease.

Yet in spite of the importance of physical and mental health to successful living, not enough

stress is being placed today on functional health programs. Very few children live at a level of physical and emotional efficiency possible for them to attain. Many are handicapped by physical defects which can be corrected; thousands are needlessly suffering from the after effects of acute infections; numerous are scarred by accidents which might have been prevented; and far too many are unable to adjust themselves satisfactorily to their surroundings and to the demands of modern life.

It is estimated, for example, that in some areas of Ohio, at least 45 percent of our children are suffering from malnutrition; 75 percent have one or more carious teeth; 4 percent have defective hearing; 20 percent have impaired vision; and 15 or 20 percent have serious emotional conflicts.

Children with health problems and sundry disabilities are to be found in every school in the State. The kind and the severity of the health problems found among school children will vary, of course, in different localities. In some communities, undulant fever may be a serious health problem; in others, malnutrition may be a major concern of the people.

Responsibility for Child Health

To conserve and improve the health of our children is the joint responsibility of several groups and agencies. No one group can possibly do the job alone. Only through the cooperation, the understanding, the pooling and utilization of the resources and facilities of all agencies interested in child health can effective health programs be organized and developed. In the total health program, the school has a definite responsibility in providing facilities, trained personnel, experiences, and instruction which will help children develop desirable health practices, attitudes, and knowledge leading to healthy and well-integrated personalities.

The Basic Health Needs of School Children

What are school children like? For one thing, they are different. Some are tall, some are short; some are large and some are small. Some are strong and healthy; some are weak and frail. Some are happy and well-adjusted and some are maladjusted and insecure. Some are aggressive and some are listless. Some are well-dressed and well-groomed, and some are slovenly and unattractive. In most schools, they will represent homes

¹ Delivered at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

of various degrees of social and economic levels and will be the products of numerous political, religious, cultural, and national backgrounds.

But regardless of their backgrounds and heritage, all will have definite needs which must be met if their potentialities for security and health, both in childhood and in adult life, are to be fully developed. All children need considerable help and much guidance from many sources if they are to achieve their life goals and ideals. Schools, by the very nature of the purposes for which they were established, must assume a major role in helping pupils meet their problems related to growth and development. Failure to do so means failure to achieve one of the most important goals of education. Some of the most important basic health needs of children for efficient living are the following:

1. Good nutrition.
2. Opportunity for play and recreation.
3. Sufficient rest and sleep.
4. Correction of physical defects.
5. Freedom from disease.
6. Satisfying experiences which bring joy and happiness, promote emotional development, and a growing sense of security.
7. Opportunities to develop a social outlook on life.
8. A healthful and wholesome environment in which to live.
9. An opportunity to learn how to live efficiently.

The health needs of the growing child and the health problems of his home, his school, and community provide the basis for the school health program. They indicate the health services that the school should provide, the kind of physical and social environment essential for maintaining and promoting the growth and well-being of the child, and the nature of the problems which should be studied in health and related areas.

There are many sources, such as parents, former teachers of the pupils, health departments, physicians, nurses, counselors, the school health service department, and the pupils themselves, which should be utilized for determining the health needs and problems of school children.

Scope of the School Health Program

The scope of the program essential to meet the health needs of school children is quite broad. It includes mental, emotional, social, as well as physi-

cal health; it has social implications as well as personal aspects. To illustrate this point, the following statement was made in a letter which I received recently from one of the county school superintendents in Ohio:

The opening of school has been a nightmare. Giving just reasonable care to the 522 additional kindergarten children (40 percent increase) has been a challenge. *The health of these children in inadequate housing is of prime importance.*

To be effective, the school health program must emphasize all its phases. It cannot stress one aspect and neglect others and expect satisfactory results. It must give adequate consideration to all the factors which are included in a total health education program:

1. Healthful school environment provides a physical environment consistent with acceptable standards of lighting, heating, ventilation, and other environmental factors; the establishment of wholesome teacher-pupil relationships; the organization of the school day in such a manner that makes for a safe and sanitary school favorable to the development and adjustment of both pupils and teacher.

2. Health services combine the following activities designed to determine the physical and emotional health status of the pupils, to prevent disease, and to secure the cooperation of parents and pupils for correcting defects and maintaining health:

- a.* Thorough health examinations periodically and on referral of teachers and nurses.
- b.* A health history of each pupil.
- c.* Daily observations and careful screening of pupils by the teacher.
- d.* A well-planned and vigorous follow-up program for the correction of defects.
- e.* Emergency care following accidents and sudden illness.
- f.* Adequate protection, including acceptable exclusion and readmission policies, for all pupils against communicable and infectious diseases.

- g.* The immunization and vaccination of all school children.

- h.* Special provision for handicapped children and modified arrangement of the regular school program to meet individual needs.

- i.* A school lunch program based on sound educational principles and providing a nutri-

tive and appetizing meal daily to children who have lunch at school.

3. Health instruction refers to the organization of learning experiences which are directed toward the developing of desirable behavior, attitudes, and knowledge about health.

All of these phases of the program are closely interwoven and interrelated. These interrelationships must be fully understood and applied by the classroom teacher and other members of the school staff if an effective school-health program is to materialize.

Importance of a Healthful and Wholesome Environment

Every child spends many hours of his life at school. Since the kind of school which he attends—the physical factors of the plant, the appearance of the classroom, the personality of the teacher, pupil-teacher relationships, and the organization of the school day—are important factors in influencing the child's mental and physical well-being, much attention must be given to this phase of the program.

Not only should everything possible be done for providing the best there is for safe, comfortable and healthful living, but at all times the school should exemplify the very best practices and patterns of living which promote maximum physical, mental, social and emotional health. Learning takes place, not by precepts, but by examples. From an educational viewpoint, it is folly to set up desirable and appropriate goals of health if the school itself violates principles of healthful living, or, if the environment is such that it is impossible for pupils to practice desirable health behavior.

Provision for a wholesome environment is a joint responsibility of the community, the administrator, the teachers, the pupils and the custodian. School plants need not be unhealthful just because they are old. In most instances, even though facilities are antiquated, much can be done to provide a satisfactory environment if the desire is supplemented by paint, materials, repair, fixtures, a little effort, and good housekeeping.

The teacher's responsibility for healthful school living consists of taking charge of living conditions in her own classroom and attempting to bring about improvement in the facilities and their use. By utilizing committees—housekeeping committees, lighting committees, safety committees, heat-

ing and ventilating committees—and by organizing many health lessons around the problems found in the school environment, much can be done to improve the health education program in the school.

Relation of Teacher to School Health Program

In order to maintain and improve the health of children, many services must be provided for them while they are in school. These include services related to the care of emergencies; to the prevention and control of communicable diseases; to determining the health status of pupils; and to the correction of remediable defects. These health services to children, whether they are given in the school or in the community, also provide excellent opportunities for health instruction and should be utilized by the classroom teachers and health service personnel for their educational values.

The time has passed when health services can be performed with little or no regard to health education. Unless the health service and the health instruction programs are closely coordinated and synchronized, much of the effectiveness of each will be lost.

The child's participation in such experiences as the health examination and the dental health service program, for example, will be meaningless without an explanation of the significance and meaning of these services. In like manner, the health instruction program, unless it is related to the everyday experiences of the child, will be sterile and uninteresting.

In recent years, there has been a growing tendency to view school health services as a cooperative undertaking between school and community in which the teacher plays an important role. Experience has shown that if the teacher is left out of the planning of the health service program and is not included in its administration, worthwhile results are extremely difficult to achieve.

The classroom teacher has definite duties and responsibilities in connection with the school health service program. She must make daily observations of her pupils to detect deviations in their health behavior; she must conduct screening tests, and act as liaison between the pupil, the parents, the physician, the nurse, and other professional personnel. In order to perform her duties effectively, it is necessary that she have definite skills and knowledge of her responsibilities.

Need for Health Instruction

In order to offset many of the wrong impressions that the child will get outside the school, it is essential that the school provide in its curriculum a sound and well-organized health instruction program. Children need accurate and scientific facts about matters pertaining to health to help them avoid the handicaps and ill-effects resulting from unnecessary illness, accidents, and poor adjustments. They need experiences to counterbalance the health superstitions and fallacies that still persist among certain people.

Providing essential health instruction for our population is a major responsibility of the schools; no other institution is in as strategic a position to do this job as well as our educational institutions. They have personnel trained in educational methods and techniques; they have all the people at a time in their life when they are susceptible to education; and they have the facilities and resources for an educational program. Moreover, the school is the one institution established primarily for educational purposes.

* * * * *

School Health Education Program

In the supervision, organization, and administration of the school health education program, the Ohio Department of Education wishes to indicate the relationship of the major health problems being studied by the Commission, to the school health education program as herein outlined:

1. The current shortages in health personnel affects the extent and quality of the school health service program.

This program needs and requires the specialized services of physicians, dentists, nurses, psychiatrists, psychologists, health educators, sanitarians, and other allied professional workers who have the technical "know how" in conducting the various phases of the school health service program.

About 88 percent of the schools in Ohio depend upon local, county and district health departments to provide personnel for such services as health and dental examinations, tests for vision and hearing, immunization and disease control programs, the follow-up program for the correction of remediable defects, sanitary inspection for water, food, sewage, and garbage disposal, and many other services affecting the health and safety of the school and community.

2. The adequacy of local public health units is essential to carrying out an effective school and community health education program.

The school health program must be coordinated with the community health program. Conserving and improving the health of school children is a joint responsibility of the home, the school, and the community—a responsibility which can not be fulfilled without the mutual understanding and the close cooperation of all agencies concerned with the growth and development of the child.

A local public health unit should be able to provide for all the needs of all the population in a community. What this should consist of should be determined jointly by all official and voluntary health agencies in the community.

3. There is need for establishing and maintaining special diagnostic and treatment clinics in mental hygiene, family relations, and other areas. We must find some ways and means for conducting effective follow-up programs for the correction of remedial defects. This problem has a definite relationship to problems 1 and 2 mentioned previously.

4. There is need for more and better trained teachers in health education. This applies not only to the classroom or academic teacher, but also to the training of specialized teachers in health education.

I am sure that the findings of this health commission, based on the study of the basic health needs of our Nation, will be either directly or indirectly related to the conduct of an over-all program of health education which is essential in the schools of our State and in the schools of the Nation.

Responsibility for School Health Exam

Commissioner RUSSEL V. LEE. Do you think health examinations should be done in the schools under the supervision of the educators?

Mr. LANDIS. I think that the job should be the responsibility of someone; that it is done either by the local health units with the help of the services which they have with their medical personnel—they have the know-how; it may be the responsibility of these local health units; it may be the responsibility of the board of education, or it may be a joint responsibility. That is the professional thinking on that problem to date.

Commissioner LEE. What about immunizations? Are they done in the schools?

Mr. LANDIS. Immunizations are done as a rule by those physicians that are delegated with the responsibility, in many cases it is the private physician. In some instances it may be the school health service as indicated.

Commissioner LEE. Is it regarded as a school function, the immunization and school health program?

Mr. LANDIS. I think the important thing is that the immunization program should be accomplished by those delegated by law to perform those services.

Commissioner LEE. The question has come up in previous hearings as to the division of authority. Should it be the responsibility of the public health unit, the educator or the private physician? That is the type of question we have.

Mr. LANDIS. Personally I feel that the immunization program and the school health services, as I tried to develop briefly in the presentation, should be the joint responsibility of both the school and the community.

How you work that out depends on the local situation.

Nursing Education

Commissioner LEE. This question may not be in your realm. Should the State educational system take on in addition to its present functions education of nurses and so-called paramedical personnel as part of the State educational system?

Mr. LANDIS. My own personal opinion is that again there the State education department needs to work closely with the State health department, with the professional organizations in medicine and nursing, to work out a plan of training.

Just how much in the way of educational courses should be included needs to be determined.

But again there I think it should be worked out jointly.

Commissioner LEE. We have had from everybody that has appeared before us, with the exception of the MD's here and elsewhere, a plea for more personnel. They want more nurses, more technicians of all kinds. We are looking for ways to suggest how this personnel can be obtained.

One of the suggestions is that it be made a State educational system responsibility.

Mr. LANDIS. I think that is a partial solution to that problem, and it seems to me that the colleges and universities could well take on the responsibility for training additional specialized personnel as needed.

Statement¹ of

MRS. MARY KASTEAD

Executive Secretary

Detroit Federation of Teachers, AFL

Detroit, Michigan

The teachers believe in a preventive rather than a corrective health service, although both are needed in a functional and efficient health department. I might say that they believe as do the Chinese who "hire their doctors to stay in good health and discharge the doctors when they become ill". The royal doctor of the early centuries of China was often put to death when his royal patients became stricken. Even centuries ago these people believed that it was more important to stay well than to get well.

To recommend a corrective program to this health commission would be a tremendous task. Therefore, I will not attempt to give you an all over program, but will briefly point out to you the areas wherein improvement can be made in the public health services to children.

Lengthy Surveys Scored

In the first place we strongly object to the continuation of lengthy surveys that usually yield little or no progress. Many of them are ended when they are completed. Little is gained and great sums are usually expended. It is the consensus of most teachers that the health program of this city is inadequate. For most certainly the services rendered are limited and discriminating. The program must have been inadequate in the past or the U. S. military service would not have found that a large percentage of our boys and girls were neither physically nor mentally fit to adjust to military training. Yet, we believe that many of these same individuals would have been acceptable had their defects been detected and corrected in their early years.

Every American child should have a physical and dental examination every year. Then the existing physical defects would be discovered before they become rooted. It is not sufficient to discover an illness, there must be a follow up. This is one of the main factors that make the present program inadequate.

¹ Delivered at Regional Hearing at Detroit, Mich., September 23, 1952.

Children in Lower Income Families

In the early part of each semester the physical education teacher, the counselor, and the home room teachers screen their classes for general defects and evidence of illness. If the child is of a welfare family he can be treated at once. If the child comes from a home that has a sense of social and domestic responsibility, he is also treated very soon. But, if the child is a member of the lower income brackets, he is deprived of the school doctor and dental treatment.

When parents are working and earning, they are expected to provide for the medical needs of their children. And thus we would seemingly punish the child whose parents do work and do make an honest effort to provide for their families.

Children on welfare or agency aids are much better off as you will conclude. The teachers maintain that the parents of the lesser income groups should be helped and aided in meeting their responsibilities when they find it impossible to meet the demands made upon their incomes. In these cases it is the child who is exploited, for it is his physical well-being that is neglected.

I recall an orthodontist case in one of our high schools. He was an intelligent and pleasant lad with an extreme over bite and had a very wide split between his front teeth. He had an unbearable lisp. He finished a trade school with honors, and yet no one would hire him. A dental correction should have been made during his early years. Think of the damage that was done to this child.

Surely there are means in this country of ours to meet these emergencies. And they are tragic to these individuals. Many cleft palate and denture cases grow into adulthood hampered by inferiority feelings that come with these handicaps.

No Follow-Up

Health teachers are consistently complaining that there is no follow-up in correction cases. There is no place they can put the responsibility for medical treatment. There are not enough medical men assigned to school work. Physical defects are often discovered in the first or second grades. The child climbs on up into adolescence; then many of them become too ill to continue their scholastic training. Eventually these children become dependent individuals in our society. It would have been cheaper economically had we kept them healthy.

Counselors literally beat their head against the wall to find ways to send boys and girls for medical attention. Many pupils arrive at adolescence with weak hearts, poor eyesight, anemic blood, very bad posture and many are victims of malnutrition—hence they become tuberculosis cases. I am informed that local conditions block a systematic X-ray check and examination of all school children. I believe that if every school child had a chest X-ray every year we could in a period of say, ten years, reduce our cases of tuberculosis more than 50 percent.

The Detroit teachers cannot offer the solution to all of this but it is to be assumed that our children have a birthright and that is their right to grow and mature into healthy adults. For there exists in this Nation no greater values than our posterity.

School Nurses

Now, what do we recommend?

We would like to have school nurses trained especially to work with school children. The public health nurse does not have the time to do a coordinating job with the teacher and counselor. Neither does she have the time with all of her duties in her district to coordinate the health programs that teachers should carry on in their classrooms. Yet this should be the basis of a proper network necessary to promote healthy children.

Examination and Corrective Medication

We further recommend—

1. A physical and dental examination and a blood analysis with a follow-up of corrective medication to alleviate health problems for every child in the city—once a year.

2. A chest X-ray for all school children every year.

3. Medical treatment must be rendered without cost. Then all children regardless of economic status would be permitted to develop and mature into healthy adults. For if we would have a strong and virile Nation the youth of each generation must be of good blood and strong of body.

Therefore, I believe it is the duty of the Federal government to promote for all children a complete and extensive health program.

Commissioner RUSSEL V. LEE. Mrs. Kastead, who do you think should do all this health examination of school children? Should that be done by the local boards of health, or by whom?

Mrs. KASTead. I do not know. I am not a government expert. It certain is the responsibility of probably the government.

Commissioner LEE. There are at least 15 million children in the group you are referring to—that is a lot of examinations to do every year. What about personnel for such a program? Where would you suggest they come from?

Mrs. KASTead. I do not know, but what is more important than the health of our children?

Commissioner LEE. We have to find some practical answers to some of these idealistic yearnings too, and I just wondered if you had anything specifically in mind as to how such programs should be set up.

Mrs. KASTead. I do not think this is idealistic. I think it is a necessity. Just because a child happens to be born in a lesser-income group is no reason he should not be permitted to grow into adulthood.

I know from my experience of many years that we often have children in the middle class groups who cannot afford to have their illnesses taken care of. Welfare wishes can be taken care of. That is not fair. I think it is the Government's responsibility.

Commissioner LEE. Federal, State or local?

Mrs. KASTead. Let them all share it.

Commissioner LEE. That is all.

A VOICE. You mention the fact that there is malnutrition among children. That is a home problem. The Government cannot take care of that.

* * *

There again I do not think we can absolutely control some of the people in the care of their children. We can do it to the best of our ability but when we come to control them in their homes we can not tell the parents, "You must do such-and-such."

This is a free country and let us try to keep it that way.

**Statement¹ of
RUFUS A. PUTNAM
Superintendent of Schools
Minneapolis, Minnesota**

... One of the most important objectives of education is the maintenance and improvement

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

of the physical and mental health of boys and girls in our schools.

Administering, planning, and carrying forward a health program which will help boys and girls achieve this objective during their school experience is the real concern of our school administration.

Health Problems of the School-Aged

Following for your consideration are some of the problems which school systems face today in trying to meet the health needs of school-age children, and I have attempted to enumerate them under six questions:

1. How can adequately trained and qualified personnel be secured so as to insure a sound educational program for all children in our schools?

The success of the present day program of education and of our health program for school children depends upon the extent and quality of the leadership of the classroom teacher. The classroom teacher is the "key" person in the health program, as she is responsible for conducting all the health activities in the curriculum.

Therefore, if this teacher is to plan a program of instruction and guidance, so that the needs of each child can be met, the class size must be limited so that attention can be given to individual children.

Under the present program, where teachers have 40 or more pupils in a class, it is impossible to give sufficient attention to the physical and mental health needs of each child. Therefore, in our schools today we are vitally concerned about the problem of large classes and shortage of adequately trained and qualified teachers. Our expanding school population makes this problem doubly serious and gives it an emergency status.

Attention to the selection and education of specialized health personnel for schools is a very important factor to which we must give consideration.

To better understand the health needs, and guide individual children in meeting these needs, classroom teachers should be provided the help of professionally qualified health personnel.

Solving the Personnel Problem

Important factors in the solution of the problem of securing sufficient and adequately trained personnel for the health program of our schools today is the recruitment of teachers and the securing of

funds to provide such a program. School systems need the help of Federal, State, and local agencies in meeting this grave problem.

The second question is, how can diagnostic and treatment services for school age children be secured?

Through the use of modern and efficient screening techniques and teacher observation, greater numbers of children with health problems are being discovered in our schools. However, many of these children are not able to have needed diagnostic and treatment services, either because facilities are lacking in the community for this kind of help, or because financial resources or financial reasons make it impossible for the family to secure this help for the child. This need for resources is apparent in the field of dental health, medical, and psychiatric services.

Mental Health Facilities Nonexistent

Diagnostic and treatment services for children showing symptoms of mental and emotional disturbances are virtually nonexistent. Mental health clinics need to be provided for children in the metropolitan area, this Minneapolis metropolitan area. Also, more professional mental health services are greatly needed to assist parents, teachers, and others concerned in meeting the needs of children and to provide treatment for children with more difficult problems.

The third question which I wish to pose is, how can school age children be protected in case of illness or in case of accident?

Well, it is common practice in cities and States to protect those participating in interschool athletics by having them subscribe to some type of health insurance. However, children who participate in recreational and other types of physical activities in the school program do not have the benefit of such health insurance. This problem might well be considered by the health commission as a need in the area of health and safety.

Expansion of School Building Program

The fourth question I have is, how can we secure sufficient personnel and financial aid to assist schools in meeting the needs of children whose mothers are employed during the school day?

There is an increasing number of mothers employed in industry. Therefore, many preschool and school age children are not having the supervision and care in the home which they should

have, and much of the responsibility of caring for these children is put upon the school.

Some attention needs to be given to the development of nursery schools and child care centers so that these children can get the supervision and care they need. Financial support as to staff and program might well be provided through Federal, State, or local expenditures.

Also, children need a hot noon lunch when it is not possible for the home to care for this responsibility. Again, the school is called upon to make such provision. The Federal government, through its financial support, and the local school system, in providing lunchrooms, have done a great deal to help make this hot-lunch program possible for many boys and girls. More attention needs to be given to this program both as to financial support and to making the hot lunch a regular part of the school program.

Provision of a Healthful Environment

The fifth question is, how can we provide a healthful environment for children to live and learn?

Rehabilitation of existing buildings and construction of new schools is a must for the school system. Many of the schools which our children attend are not as healthful from an environmental standpoint as the industrial plants where their parents may be employed. With the increased enrollment, new schools are overcrowded almost before they are open. Therefore, it is imperative that an active building program be carried forward in our schools. The school system, with its present financial income, cannot adequately provide the kind and number of school buildings which are needed.

And the last question, No. 6, is, how can the schools make their health education programs effective?

To provide a health education program in our schools so that every pupil, 1, receives adequate instruction in basic understandings of healthful living; 2, guidance in correction of impairments; 3, protection against environmental hazards; and 4, an environment which is ideal from the physical and emotional standpoint, means that every person on the school staff is qualified to participate effectively in the program. To help schools achieve this program, teacher-education institutions need to give teachers in training the kinds of experience necessary for acquiring these leader-

ship and teaching skills. This means an expanding program, both as to staff and facilities, in most of our teacher-education institutions.

Statement¹ of
CHARLES E. SPENCER
Director of School Health
Coordinating Services

*A School Health Program for Helping
Medically Indigent Families*

It should be pointed out that in the rural areas of North Carolina the present school health program is not meeting the school health needs . . . Thousands of children of parents who can afford to pay for medical services are not getting them because of lack of understanding of the importance of early correction or failure to recognize the need for periodic medical and dental examinations. Health education is needed even more than medical services, but trained personnel is not available even when State funds are provided.

The State Board of Education allocates the \$550,000 annual appropriation as grants-in-aid to city and county school administrative units for school health work. These funds are allocated as follows:

- a. Each county and city school administrative unit is allotted an amount equal to 50 cents per pupil based on the average daily membership for the first 7 months of the previous school year.
- b. In addition \$1,000 is allotted to each county regardless of size. Each school administrative unit within the county will receive a portion of the \$1,000 allotment based on its percentage of the total students in the county.

School health funds are channeled through city and county school superintendents in the same manner as other school funds.

In addition to State Board of Education school health funds the State Board of Health has earmarked for school health an amount equal to 40 cents per pupil in average daily membership to county, city or district health department.

School Health Funds

School health funds may be spent for the purposes listed below:

- 1. Medical, dental, nursing, education psychiatric, technical and allied personnel, on a full or

part-time basis. Helping-teachers or supervisors of health, physical education, and safety may be employed, but teachers for classroom instruction should be paid as formerly.

- 2. Fees for clinicians services (examinations and other diagnostic services).
- 3. Correction of chronic physical defects for school children whose parents are unable to pay and only when funds from other sources are not available.
- 4. Travel of personnel and transportation of children to clinics and hospitals.
- 5. Supplies and equipment essential for conducting a school health program.
- 6. For approved in-service training programs.

In the final analysis the success of the school health program will depend not only upon the expenditure of the school health funds, but also upon the cooperation of all agencies and persons concerned. Teachers, nurses, supervisors and principals who are closer to the health needs of children, should be able to assist the superintendent in planning and carrying out the details of the school health program. For example, a teacher screening program planned jointly, by the health department personnel and the school personnel including the principals and teachers is one of the first and most important steps in determining some of the major health needs of children.

Statement¹ of
DR. LLOYD L. TATE
Child Hygiene Service
Board of Education
St. Louis, Mo.

I am with the public schools of the city of St. Louis. When school opened in September, there were some 100,000 children. In order to better care for these children our doctors, nurses and dentists, and audiometrists have been advised to take these children over.

We have tried to find the physical defects of these children, and our problem has been in taking care of these children. We have some service clubs, such as the St. Louis Heart Association, and in the last 2 years there have been, through that club, operations on some 15 blue babies—that is, children who were born with congenital cyanosis. There also have been some other operations.

¹ Delivered at the Regional Hearing, Raleigh, N. C., August 25, 1952.

¹ Delivered at Regional Hearing, St. Louis, Mo., September 15, 1952.

School Health Needs

We need in our schools more nutritionists to help children. We have made a check survey and have found that children are given money to buy lunches, and end up buying popcorn, soft drinks and maybe lollipops.

We feel that a laboratory is a very important factor in health in working up different things that we have and that we run across. I think all of our men in medical schools today are trained for the use of laboratories and feel that they need them.

Mental health has become a very big problem in the schools today, with maladjusted children, and we need to study that more carefully.

I have felt for a long while that through the education of adults, where the children have become a problem, we could achieve a great deal if we could bring the parents into the schools at night and instruct them in how to conduct—or rather, how to train their children.

We also feel on audio-vision that we can take care of some education. We have a broadcasting station in St. Louis over which we broadcast health and nutrition problems, social-hygiene problems, and so forth, in the class room. This has been picked up by the teachers and nurses, and they have been very helpful in giving us some ideas on control. We are also teaching them over the radio, and are thinking seriously of television.

I feel that the control of communicable diseases by the State is proper, that is a State problem. We have some children who have come into St. Louis who have had communicable diseases. They have been quite a problem. They would probably be isolated from our school inspection, and the first thing we would know, they would have moved out of the State.

I do feel that if we had some way of running these children down, it would help stop the spread of contagious diseases.

As to our social hygiene lectures, we hope to obtain complete X-ray and photographic control for tuberculosis.

Thank you for the opportunity to appear.

Statement¹ of

MISS ALBERTA CHASE

**Executive Director, Missouri Society
for Crippled Children
St. Louis, Mo.**

We need a coordinated program for the medically indigent, general in character, which follows through and completes the precedent already established by some of the counties for patients receiving public assistance, the majority of whom, according to the State Division of Welfare, are physically handicapped.

Now, concerning the chronically ill. We need a positive development program for the chronically ill—including the tuberculous and the mentally ill, and those severely disabled, such as the cerebral palsied who require custodial care—which will provide (a) adequate medical care; (b) physical and vocational rehabilitation; and (c) institutionalization, temporary or permanent, on a preventive and training basis.

The Missouri Society for Crippled Children has had experience in all of these fields, and based upon this experience, we feel that we should make positive recommendations before we can go ahead for better health services for people of the State of Missouri.

¹ Delivered at the Regional Hearing in St. Louis, Mo., September 15, 1952.

THE OLDER INDIVIDUAL AND HIS HEALTH PROBLEMS

Statement¹ of

DR. WILMA DONOAHUE

**University of Michigan
Ann Arbor, Mich.**

I wish to discuss health needs with regard to older people.

I wish to discuss it because it is a problem so

pressing at the present time that it must be attacked at once.

The 50 percent increase during the last 12 years of people 75 years of age and over, and the fact that this increase will continue for years to come, are evidence of the magnitude and the urgency of the health problems of the aging.

Need for Medical Care Facilities

Chronic illness is five times as prevalent at age 65 and over as an earlier age.

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

As the numbers of old people continue to increase, a larger number of long-term care facilities will be required.

It should be our goal to offer a constellation of services integrated to provide each individual with the type of care he needs at a cost within his means to pay and carrying out the best practices of restoration and rehabilitation. As yet, no community in the country has approximated this goal.

A new role needs to be assumed by general hospitals in caring for older people. The general hospital should:

(a) Serve as a diagnostic center and make referrals to other agencies as indicated;

(b) Provide treatment with the new drugs, many of which are making it possible to treat chronic diseases not hitherto susceptible of treatment;

(c) Practice restoration and rehabilitation techniques required to return a maximum number of older people to self-care and/or vocational competency;

(d) Educate patients and their families regarding medication and handling so that the patient can be cared for at home, thus freeing medical and auxiliary personnel and hospital facilities for acute cases;

(e) Operate hospital home-care programs enabling the patient to be housed at home and cared for by a trained staff at from one-third to one-fourth the cost of hospitalization.

Well-Adult Clinics

It is virtually impossible for older people to receive health counseling. They are advised to secure periodic health examinations but are unable to obtain them. Only a few physicians are interested in counseling well old people, and only a small proportion of older people have enough money to pay for this type of medical service.

There is, then, a need for well-adult clinics similar to the well-baby clinics. Such clinics would conserve individual and public funds by detecting incipient costly long-term illness and by teaching preventive health practices to the aging adult. A system of adult mental hygiene clinics, similar to the child guidance centers in Michigan, should also be established, because the mental health problems of the aging are as great and as susceptible of treatment as the problems of children.

Medical Care Cost Protection

One-half of older families have incomes too small to purchase the medical care they are likely to need; 76 percent of older individuals living alone have incomes under \$1,000 per year. Not more than 26 percent of persons 65 years and over, and only 15 percent aged 75 and above, have hospitalization insurance; even smaller percentages carry medical and surgical insurance. Most of the aged do not have health insurance protection because (a) they cannot afford to pay the premiums, (b) they are largely unemployed and most low-cost insurance has been up to the present time issued to employed groups, and (c) they are excluded from coverage by many companies or are entitled only to limited benefits.

The need for health insurance is greater among the aged than among younger groups because older people are prone to more and longer illnesses and are unable to reestablish savings depleted by medical care costs. In a 1950 survey, it was shown that one out of seven couples receiving old age and survivors insurance had one or more members hospitalized during the year; of these 65 percent incurred medical expenses of \$200 or more—an amount which depleted family savings in more than half of the cases.

Inability to maintain health insurance causes many old people to neglect chronic illness; some obtain medical care only by sacrificing other essentials to healthful living; others resort to care whose cost is borne by younger and middle-aged groups, either as family members or as taxpayers-at-large. Provision needs to be made for some adequate type of health insurance, private or public, that will make it possible for older people to protect themselves against unexpected and unpredictable medical care costs. I favor an insurance plan, because illness strikes unevenly among the aged, just as it does among younger people.

Work-Connected Health Examinations

In the interest of the national economy and the adjustment of the older individual, I believe that compulsory retirement policies must be replaced by flexible retirement programs—that is, retirement must be based upon the productivity of the individual rather than a fixed chronological age.

Flexible retirement is feasible if more health examinations are provided, stressing geriatric factors in particular, in order to keep the aging worker functional for a longer time and to per-

mit the industrial physician to serve as a member of the team that decides whether a worker is to be continued in his job, transferred to work more suitable to his changed capacities, or retired. If this is not done, there will be a growing population of financial, medical and psychological dependents that will make ever-increasing drains upon the economy, the family, and the health facilities of the Nation.

The large number of industrial workers in Michigan who are subject to enforced retirement makes this a problem of particular importance in this State.

Need for Preventive Measures

In Michigan, as in other States, concern is mounting over the number of older people who are committed to mental hospitals or who become permanently disabled as a result of chronic illness. Medical and psychological research indicates that physical and mental deterioration results from the continued inactivity that is characteristic of present-day retirement living. It is not economically sound to retire people from gainful employment and then allow them to deteriorate to a point where some type of hospital facility and care must be provided for them.

Among the things that are needed are:

Continued employment opportunity as long as the individual remains productive.

Sheltered workshops for the less able.

Activities centers for recreation and education.

Expanded adult education programs.

Community handicraft shops and markets.

And opportunities for volunteer service in community programs.

Need for Professional Personnel

The severe shortage of medical and auxiliary personnel has special significance for the aging because of their susceptibility to illness. The shortage of hospital and public health nurses might be relieved somewhat if the middle-aged woman, freed from family responsibilities, were admitted to training, and if those already trained were encouraged to return to practice. The nursing homes that are now providing the way of life for large numbers of old people are operated, in most instances, by totally untrained individuals.

Educational institutions should establish training programs for home operators, and such training should be required for meeting licensing standards.

Finally, a vigorous recruitment of young people is needed for training in physical medicine, occupational and physical therapy, geriatric nursing, and medical and psychiatric social work.

Statement¹ of

DR. GEORGE W. JACKSON

**Medical Director, Board for
Texas State Hospitals and Special Schools
Austin, Texas**

Every civilization and culture since the beginning of time has been faced with at least one basic problem which has been common to all. That problem, of course, has been what to do with the aged and the infirm who, due to the incapacitating effects of biological degeneration, have become unable to keep pace with the other members of the society.

In bygone ages, the number of older citizens within any given population was exceedingly small when compared to the over-all size of the group; however, these individuals, although they were few in number, often disturbed the mobility of the society and interfered with the socio-economic structure of the culture, for even in a primitive society a man or woman who could not procure his or her share of the food or move with the rapidity necessary to insure the safety of the groups actually endangered the survival of the entire society. Because primitive society operated on a survival of the fittest basis, older people who could no longer carry their share of the work load or keep up with the group, were singled out, given a small amount of food and left to the care of the elements.

This revolution which accompanied the change in attitude toward the aged naturally took place in the over-all pattern of civilization. For as cities gradually replaced nomadic villages, agriculture replaced hunting and religion replaced mysticism, culture became more closely integrated; physical strength and agility became less a necessity. Society found these people could be easily fed and cared for within the loose knit units of our early rural culture, and that they were often able, through their experience and long developed skills, to carry more than their weight within the social structure of our culture.

¹ Delivered at the Regional Hearing in Dallas, Tex., August 18, 1952.

Old Problem Reared Anew

Unfortunately, for the aged certain factors began to develop gradually within the culture of our western civilization that were to reverse again the position of the older citizens within our society. In the late 1800's a cultural revolution began to change the entire structure of our western civilization, and within a period of a few decades the position of the aged had virtually reversed itself. We had entered the "machine age."

Unfortunately for our aged, technological knowledge and industrial know-how far outstripped our social sciences and developments, and the aged were forced to enter the 20th century living in a culture that was geared on one hand to the atom, and on the other to the wooden plow.

As we enter the last half of a century that has seen marked strides in the development of industry, sciences and public health, we find ourselves again confronted with an extremely ancient question, namely, "What should we do about the aged?"

If we are to understand the problem of the aged and make a reasonably intelligent approach toward solving it satisfactorily, we must have at least some knowledge of its ingredients.

Population Structure in 1900

If one drops back to the year 1900 and studies the population structure of the United States, he will find that he is dealing with a young and active culture, predominantly rural in nature, with a high birth rate and a rapid intake of young immigrants.

Within this culture one will find that a great number of children and young adults died from disease during the early years of life and that only 3 million people, or about 4 percent of the total population reach the age of 65 or above.

Amazing Change

Comparing this culture to the structure of the same society 50 years later, we find that a number of rather amazing changes have taken place. In the first place, our over-all birth rate, with the exception of recent "baby booms," has been consistently falling; the size of the average family has diminished; immigration of young people has virtually stopped and the mortality rates among infants and children have become exceedingly low.

With these changes have come a marked increase in the number of aged within our culture and an over-all increase in the ratio of aged to our total population. Actually, the number of aged has increased from 3 million in 1900 to 12.4 million in 1950, and the ratio of aged within the population has jumped from 4 percent at the beginning of the century to 8 percent at the halfway mark.

In other words, our decrease in over-all birth rate, the cessation of immigration of young people, and decrease in infant and young adult mortality have resulted in a situation which has allowed our older age group to quadruple itself while allowing our over-all population only to double itself in size.

18,000,000 Aged in 1975

If the present trends in birth rate and mortality continue, we can be assured that by 1975 we will have at least 18 million aged in our population and that such individuals will represent a large percentage of our population.

Now, what makes them a problem? I think I have mentioned part of them: People living in small apartments; many husbands and wives working, and the mechanism of industry and the establishment of retirement ages.

Since the turn of the century, our population has become increasingly urbanized and industrialized and with this shift has come a change in living habits of our people.

In the early days when most of the people lived on farms in rural settings with large homes and plenty of individualized work, the aged in our population could be housed and cared for without interfering with the over-all activity of the family group. There were jobs for everyone to do, and these jobs varied in the amount of physical and mental effort necessary to effect them. In this situation there was work for all but the most severely handicapped persons. Added to this was the fact that families were large and there were always hands available to help handle and feed the disabled or infirm.

This picture has entirely changed in the past 50 years, for now instead of the farm with its large family group, we have the modern efficiency apartment or small home with its one or two-child family. Few, if any jobs are available in or around the modern homestead and there is little escape from the noise and bustle of what we are prone to call modern progress. In this new

situation there is no work adaptable for the old and the infirm, and there are no friendly hands to guide and feed them in time of need.

Along with this change in our home life and social structure has come a change in our industrial and business policies, which has also adversely affected the adjustment of our aged citizens.

Time a Premium

When businesses were small and were operated on a more or less family basis, there was always some work available to all but the most incapacitated aged worker. Skill with the hands and perfection of product were premium items; time was relatively unimportant.

With mechanization and its bedfellows, technology and the production line, skill with the hands has become virtually nonessential and time has become an all-important factor. Youth with its stamina and agility has become a premium item, whereas age has become a disqualifying factor.

As the machine has largely eliminated the need for strength and has replaced it with the need for manual dexterity, women, who in centuries past remained within the home, have left their former duties within the household and have flocked in ever-increasing numbers to the business world.

Older Worker Pushed Out

All these factors have naturally gradually but consistently pushed the older worker out of modern industry and business and have brought forth rules and regulations that have forced out citizens from their jobs at 60 and 65.

As our society has laws that determine when an individual may start to work and precedents which determine when he must stop, the period in which an individual must accumulate his nest egg has become gradually shorter. Pay scales have naturally gone up, but the cost of living has risen commensurately and taxes have progressed far in excess of either.

With a relatively shorter work life and a markedly higher cost of living, it has become, in spite of our social security programs and retirement plans, almost an impossibility for a person to save enough to guarantee his maintenance and livelihood in his later years.

In this connection, it might be said that recent research has disclosed that out of 100 young men of 25 today, 65 will live to reach the age of 65. Of these, one will be above average means; nine will have enough to get along and the remaining

55 will be on the rolls of the Federal and State government for support.

Up until this point we have been talking about the national problem of the aged and before going on to a study of the solution of this situation, I should like to say a little bit about the aged in Texas, for Texas, even though it has been for years able to retain a young rural frontier-like culture, is now rapidly faced with the fact that its population like that of the other States is "aging."

Aged in Texas Increase 50 Percent

During each of the last two decades the aged population within the State of Texas has increased by 50 percent or in other words, the number of aged within the State has increased from 232,459 to 523,000 in the short span of 20 years. If this trend continues, and there is every reason to believe that it will, Texas will have 784,500 aged citizens by the year 1960.

In this connection it might be of interest that during the 1940-50 period, while the number of the aged in Texas increased 50 percent, the total population increased only 20.2 percent.

In August of 1951, when the aged population in Texas amounted to 549,148 individuals, there were some 222,097 eligible persons on the Old Age assistance rolls.

At approximately this same time, the Texas State hospitals were furnishing care and treatment to 2,978 patients in the older age group, and were admitting 23.4 percent of all new admissions from the over 65 age class. Undoubtedly, both the rate of admission of patients over 65 and the percentage of patients of this age within the total hospital population would have increased markedly had not the lack of available bed space actually forced potential patients to remain out of the system.

If one assumes that present admission rates will remain the same in Texas, it is obvious that the State mental hospitals will have to process some 12,000 patients 65 and over during the next 10 years, and will end the year 1960 with some 5,000 more aged patients on its rolls than it has today.

Savings for Twilight Years

Like any health or welfare problem, the answer to the aged situation lies in prevention, rather than in care. Therefore, we should attack the problem by eliminating the factors that produce it.

Obviously, if our older citizens could amass during their productive years a sufficient amount of savings or insurance to tide them over during the twilight period of their life, they would be far less apt to become a burden on the remainder of the group.

To effect a remedy in this situation, of course, would necessitate the development of some system that would guarantee the buying power of the dollar at the time it was to be withdrawn from savings or the value of the pension at the time it was to become effective. Actually, a large number of our older citizens today planned their incomes so as to be independent during their later years and find themselves faced with becoming wards of the State, due to the inflationary changes in our economy.

If a man or woman cannot save a sufficient amount to keep him or her during old age, then certainly some arrangements should be made to allow our older citizens to work for a living. Today in Texas, only 23.5 percent of our aged are working and it is doubtful that there will be a higher percentage increase until business and industry change their attitude toward the competent older worker. In a Nation such as ours, with its tremendous industry, there should be available work for an extremely high percentage of our aged.

Actually, a change in our industrial and business attitude as they affect the employment of our older citizens, would not only do much to stabilize the economy of this group, but would actually help stabilize the mental and physical health of these people.

Recent studies of which I am sure many of you are acquainted, have proven that the incidence of physical, and especially mental break-downs in our aged, can be greatly reduced and at times almost eliminated, by keeping our older citizens actively and constructively occupied. Certainly, there could be no better preventive therapeutic measure for an older individual than placing him on a job that he likes and that makes him at least a semblance of a living wage.

Social Clubs for the Aged

If socially minded groups within a community, or the community itself, would establish and maintain special centers for the aged, they could do much toward improving the over-all welfare of their older citizens. If a club or organization

within a community would rent a building or area and establish within it a meeting place for the aged, complete with recreational facilities, hobby shops, dance floor and snack bars and then turn the entire project over to a group of enterprising oldsters, they would find that many of the communities' problems revolving around the handling of the aged would disappear.

In actual practice, it has been found that such clubs have decreased the incidence of mental break-downs among the aged as much as 100 percent within 1 year and peculiarly enough have decreased the admission rate of oldsters into general hospitals by as much as 50 percent.

The secret of a good old folks center is first, to make it available to old folks from all walks of life, and to eliminate from it the stigma of charity. The second factor is that the old folks must be put on their own to maintain and operate the organization with little or no control or supervision from the founding organization or supporting group. Actually, when these factors have been kept in mind, such centers have been successful; conversely, where they have been disregarded, the clubs have failed.

Obviously, a center such as this offers many direct benefits to the aged; it allows them to get away from the crowded confines of the family group during most of their day, thereby eliminating a considerable amount of inter-relations conflict. It also allows the young members of the family, where circumstances require it, the chance to follow a remunerative profession without having to worry about the welfare of an aged relative left unprotected within the confines of a home.

It gives the older citizens a chance to converse and mix with individuals who feel and understand his problems and accomplishments. It makes available a place where a man or woman can continue his or her hobbies and where he or she can keep constructively occupied. In other words, such a center gives the older citizen a place of refuge that is geared to his physiological and mental speed and also an area where he can retreat from the hustle and bustle of a culture which is operated for and controlled by younger men.

Adequate Care and Treatment

Obviously, none of the aforementioned procedures are going to solve all of the problems of the aged, and we will have always the problem of caring for those who become psychologically or

physiologically incapacitated. Actually, this portion of the problem, however, could be made an extremely small one if adequate preventive measures could be placed in effect.

As the problem of furnishing adequate care and treatment to the disabled and infirm among our aged group is a real and rapidly growing one, it is essential that we devote at least a little time to suggestions for the solution.

Actually, there are few truly psychotic patients among the aged who develop neurological or mental symptoms and, therefore, the answer is certainly not to hospitalize all those who develop mental changes.

If one closely studies the patients over 65 who are sent to a State mental hospital, he rapidly discovers that they readily fall into three main groups; namely, those that could be adequately taken care of in a convalescent home or foster home; those who should be in a specialized geriatric hospital and occasionally, a rare case that should be in a true neuropsychiatric unit.

Actually, a large percentage of elderly patients presently hospitalized in this and other States could be easily cared for in properly operated convalescent and nursing homes, if such homes were available and money could be found to place the aged in them. As even the infirm and the disabled among the aged recover faster or at least become easier nursing problems when hospitalized in their own community near their old surroundings and their old friends, it behooves communities to encourage the development of convalescent homes and hospitals within their own areas.

The Texas State hospital system has already recognized its problem in relation to the aged and has set aside certain of its units for the care and treatment of gerontological cases. The State at present has over 2,200 special treatment beds devoted to the specific care of the aged and will create more beds as funds become available.

Actually, by designing hospitals to meet the needs of the aged and staffing the hospitals to handle the problems that are presented, the State can effect a considerably saving in operations cost and still offer far better treatment to the aged.

In fact, the problem facing the Texas State hospital system at the present time is not how to effect rehabilitation or recoveries in its older patients, for its staffs are rapidly finding these answers; the problem at the moment is how to convince the family or community that the case in point is ready

for discharge and that he should be removed from the hospital.

Statement¹ of

DR. WINGATE JOHNSON

Bowman Gray Medical School
Winston-Salem, N. C.

I think that the subject of the growing problem of senility and what we can do about it, boils down to the statement that senility is really the problem of senescence, and when we get to the end of one's usefulness.

Steiglitz, in his excellent book on geriatric medicine, divides the practice of geriatrics, according to ages, into later maturity, which is 45 years plus or minus 5, and senility is 70 years plus or minus 10. So by the time we get to the very last stage, as senile, that is, the "lean and slippered pantaloons" age, there is not very much that we can do. What we can hope is to prolong the period of maturity and postpone the period of senility.

Not necessarily to reiterate that the proportion of older people in the population is steadily increasing, the average life span has increased as much in this century as it has in the twenty centuries before. The medical profession has done its share, but it cannot claim all the credit, by any means. Advances in sanitation and ancillary medical sciences have also contributed. The average lifetime is pretty near the biblical period of 70 years. The ladies may be interested to know that they have about 5 years longer to live than the men have.

This increased number of older people brings problems of a sociologic, economic and political nature as well as medical.

The most important problem is to see that older people are not to be pushed aside and made to feel that they can best serve society by dying. Who wants to live long unless he lives usefully to the end of his productive period?

Abolition of Compulsory Retirement

Now, what can we do? First, of supreme importance is the abolition of compulsory retirement at 65, or at any arbitrarily fixed chronological age. In 1890, 68 percent of men 65 or over were in the labor force. In 1950, there were only 45 percent. I may say that the fact that I passed my 65th birth-

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

day 2 years ago might have a bearing on that, because I have been assured that as long as I can crawl to the office at the Bowman Gray School of Medicine, I can keep my office there.

It is significant that in the first National Conference on Aging held in Washington, August 1950, 8 of the 11 sections went on record as favoring a change in the present policy of forcing workers out of employment at a fixed age regardless of the ability to continue at work. The sentiment of these 8 sections might well be summed up by this quotation from the section on religious programs:

One pattern needing change is that of compulsory retirement at a fixed age. This practice appears to deny the fundamental religious recognition of the uniqueness of the individual.

Steiglitz says that retirement rules based upon arbitrary chronologic age are so obviously illogical that ultimately there will occur revision in such policies.

Finally, Dr. Howard Rusk, medical director of the New York Times, in commenting recently on Dalton's retirement at the age of 88, stated that this announcement has highlighted the widespread discrepancy between the attitude of employment of persons and the ages of elected officials. Then he cited the case of a two-star general who originated the ideas on manpower mobilization, but who was forced himself to retire, although his last physical examination was perfect, at the age of 62, which is about the same age that the average senator becomes eligible for committee chairmanship.

1970: Pensions Equal Work

I need not stress this point further, except to point out that the burden on workers will become intolerable if it continues. The Sun Life Insurance Co. has estimated that by 1970, if the present trend continues, as many of the adult population will be on pensions as will be at work.

There is a need for a psychological test for mental flexibility, for physiological as well as chronological age. It might retire some at 40 or 45, as far as that goes. It will be worth trying.

Medically, we doctors can help mature people to prepare for later years by advice on diet, recreation, exercise, and encouraging them to develop wide interests. Incidentally, the best single piece of advice that I am offering gratis is to keep your weight down to where it belongs.

Religious leaders should heed the words of Steiglitz, that religious leaders need to take cog-

nizance of the increasing age of their flocks and broaden their spiritual interpretations to fit the critical and more mature minds of the future.

Homes for the Aged

All the regions are now recognizing the need for homes for the aged. It is frequently not feasible for children or other relatives to keep their aged relatives in their homes. The county home and the poorhouse are obsolete, but there is need for a decent, low-priced housing accommodation where old people may live in reasonable comfort.

Dr. Robertson, president of the State Medical Society in 1949, offered as one of the three recommendations a home for the aged built by the State, where they could be housed and fed and have minimal medical care at a figure which the average person could afford to pay. Such a home should be self supporting. Also, there is a need for recreation facilities for older people and for a counseling service such as the one established in San Francisco by Dr. Sylvia Martin when she herself was 70 years old—and she was 91 years old when she died a few years ago.

Finally, doctors, ministers, and lawyers, as well as social workers, are often called upon and are able to give wholesome advice as to the disposition of widowed parents or grandparents or other dependents or older relatives. An older person may just wreck the happiness of a home at a time when they should be sent somewhere else, not necessarily a State home, but some home for older persons.

Statement ¹ of

MRS. CAMPBELL KEITH

**President, Minnesota Association of
Administrators of Homes for the Aged
Walker Methodist Home
Minneapolis, Minn.**

I appreciate this opportunity of presenting to you the health needs of the aged in this area, as they appear to me. For the purpose of analysis of these needs, let us assume that the age of 65 arbitrarily denotes the basic age of those under discussion, with a further break-down of the group into: (a) Those living independently or in boarding homes; and (b) those living in homes for the aged.

I might add at this point that to me age cannot

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

be determined chronologically. It is so very much a matter of attitude. The home of which I am superintendent has an average age of 81 for the 200 that we have, but the oldest resident we have is 101. She is more active and participates in more things, and thinks more clearly than most of our people, so we will just say 65—but I don't feel anyone 65 is old, I want you to know that.

It would seem that the medical centers in Minnesota are pretty fairly adequate, as well as conveniently located throughout the State. The question of transportation to medical centers is one that might well be included as a medical problem, and could be met through organized social groups in the organization of motor corps.

Services Necessary

Because it is possible to house but a small fraction of our aging population in homes for the aged, home nursing care and counseling services are needed. Instruction should be provided in the principles of sanitation, personal and mental hygiene, as well as in meal planning and food purchasing and preparation.

In order to provide trained personnel to meet the above needs, considerable publicity is needed in arousing the interest of potential trainees. Scholarships established would be of great help in preparing workers to serve in these areas.

Mental hygiene clinics made available to, and utilized by our aging populace, I feel, would greatly reduce the high incidence of senility. Toward this end also, rehabilitation centers are highly important to those who may be attaining the established age at which they are summarily relieved of routine activity when still well able to earn and participate.

On this point I would like to suggest that a constructive piece of work might well be done with the employer, and changing the attitude of society in general. To accomplish this purpose would be a therapeutic approach to the medical problems of our aged.

Promotion of Normal Living

For those living in homes—more generally spoken of as “institutions”—there is a need for the training of personnel equipped to understand the necessity of promoting normal living for older folk. There is a direct correlation between good health and happy attitudes, in so far as older people are concerned. These constructive attitudes should begin at the level of the board of trustees

and administrator, proceeding down through the entire staff.

I feel that infirmary facilities within the home, or in close proximity to it, are to be preferred to the transporting of an ill resident to a hospital center some distance away. My reason for this is what is realized when the average resident of a home has out-lived most of his friends and relatives, and has acquired an entirely new set of social contacts. If his illness or convalescence is to be aided by friendly visitation, it is necessary for him to be in or close to the home in which he has lived.

Treatment Centers

There seems to be a definite need in this area for a center for the treatment of the arthritic, and additional psychiatric services available when needed are also indicated.

If there could be some way of developing the preparation for advanced age with its frustrations, its disappointments, and its waning strength, there would be less need for psychiatric services in the later years.

Earlier Diagnosis and Treatment

The medical problem of the aged could be eased through earlier diagnosis and treatment of many conditions during so-called “middle age,” for we know many of the infirmities of advanced age might have been alleviated, if not eliminated, had there been earlier diagnosis.

There is a great deal to be done through educating each generation and alerting them to the possibility of physical and mental infirmities that could be obviated during the middle age of the individual. Until this can be accomplished over the years, it is imperative that an increasing number of younger people be interested in the opportunities and satisfactions afforded in the field of geriatric nursing.

In summary, with longevity on the rampage, and the consequent impossibility of institutionalizing the majority of our aging population, counseling services are going to be in great demand, and could be interpreted through trained social workers, occupational therapists, and physiotherapists.

One should not forget in working with the aging themselves that there is a great deal of work to be done in correcting the attitudes of society in general toward advanced age. There is no reason why the aging should be an isolated group, but rather, there should be a stressing of the

amalgamation of all ages, adjusting with the naturalness of living with one another with confidence and with mutual respect.

Statement ¹ of

DR. HAZEN PRICE

Geriatric Committee of Michigan
Detroit, Mich.

We have been especially slow in appreciating the problems of the senior members of our society and have done very little in adult education to prepare them for the later years of life. We have been only half conscious of what the increase in the average life span means to our civilization. The problem is not only to treat old people properly when they are sick, but also to develop measures which will lessen the economic and social difficulties known to affect their physical and mental health.

Our attitude of pessimism toward the later years of life must change. Heretofore, programs have been set up on the premise of old people receding, rather than on a basis of continued growth and the beginning of a new phase of life after 50. They must continue to belong to the family and community with a definite part to play and a feeling of being needed, through doing something essential to others. Aging brings maturity in many ways, particularly in judgment and responsibility, and we are being very remiss if we fail to use this vast storehouse of experience.

Medical science has played a big part in increasing the span of life through preventive and curative medicine.

We shall continue our emphasis on preventive measures as the soundest and cheapest road to health—costing one-tenth that of curative medicine. Our profession is therefore responsible to a large extent for creating this problem. We are happy in our part of the accomplishment, but realize full well the many new difficulties it has created. About 50 percent of all persons over 65 years of age have some form of disability which poses a great challenge to the concept of rehabilitation. Their lives have been prolonged but their ability to work has not been restored.

Economic Insecurity

I would like to discuss now another phase of the aging problem. About 50 percent of the people

over 65 years of age are well and able bodied, yet many of them have no peace of mind, are bewildered, confused and frustrated. They are emotionally sick and frequently present a greater problem than if they required simple nursing or custodial care.

Careful questioning has revealed that economic insecurity is the number one cause of most of their difficulty. They fear dependency. They want to be able to buy their way in the world. They want productive occupation to keep mind and body busy.

To this end, we feel that the present fixed retirement age prevailing in so many industries should be reconsidered and made more elastic, according to individual interest and ability to work. Selective retirement should replace compulsory retirement.

There is also the group of individuals with some type of physical handicap who could be productive if some provision was made in industry for a limited type of employment. One social agency in this city is accomplishing a great deal by placing many of these people.

Problem of Long Term Illness

The other 50 percent of these people are disabled in such a way as to prevent any type of productive employment. Short illnesses can usually be cared for, but long term illnesses present a totally different problem. Retirement income is usually insufficient and old age assistance benefits supply only the barest necessities.

City and county institutions have given reasonably good care for years, but if these patients could be cared for in their own homes or in nearby hospitals by their own family physicians, they would be much happier, and convalescence would be shorter. Some form of insurance as offered by voluntary insurance organizations as a group plan, or on cost-plus basis, could be developed.

The Veterans Administration now has a working plan with Blue Cross and Blue Shield, and that could be copied by the state buying the insurance on a group basis for large numbers of the low income group.

The plan has been discussed before with state authorities, and should be given serious consideration again. This would be a solution for a problem we have had with us for a long while, and will continue in increasing magnitude as more people live longer.

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

Summary

In conclusion,

(1) We feel that the number one problem of the aging population is economic insecurity. This would be prevented in cases of those who are able to work, by a selective retirement system and more consideration given to limited employment for the partially handicapped.

(2) For those with more severe disabilities, a group insurance plan bought by the state from some voluntary insurance organization similar to that existing between the Veterans Administration and the Blue Cross organization, would help tremendously in their care and peace of mind.

(3) Licensure of nursing homes by the Department of Health would raise the standards of care and rehabilitation for the patient, thereby removing the stigma attached to such homes in the past of custodial care only.

(4) Rehabilitation centers should be an integral or associated part of every general and county hospital with cooperation where possible with college or university psychologic departments.

(5) Community appreciation of the whole problem could be given a great rise if men and women's service organizations sponsored the development of recreational groups of all kinds in every community.

(6) Coordination of all interested groups in any community is essential for the most productive work, avoiding thereby a reduplication of effort.

Statement¹ of

MR. CHARLES WARNER, JR.

**Chairman, Division for the Aged
Health and Welfare Council, Inc. of
Philadelphia, Pa.**

Older people have a problem of their own so far as health services are concerned. No large community action has been had for the health of these older citizens in the Philadelphia area despite the interest of a large group of professional and lay people.

A special committee of our Division for the Aged during the past year prepared a compre-

hensive plan for the aged, part of which is a section devoted to the special health needs.

I would like to read briefly certain sections of this report.

In order that the active and productive life of older people should be extended as far as possible, it is important that measures be taken to improve the level of health in later years. Medical attention has largely been focused upon the other end of the life span, in combating infant mortality and the diseases of childhood and early maturity.

Recently there has been a shift toward research in the chronic and degenerative conditions which, while not restricted only to later life, tend to characterize people advanced in years. Studies of the U. S. Public Health Service indicate that the incidence of chronic disabling illness is four times greater among those 65 and over than in the general population.

Prevention and Treatment

Programs of health services for all age groups should include two areas of emphasis for the older segment of the population: (1) Prevention of premature mental and physical deterioration, including the promotion of positive health, and (2) provision for treatment and care of the sick and disabled including therapeutic, rehabilitative and palliative medical services.

In planning to meet these objectives, the following would be involved: Extension of medical services and facilities; provision of health education and counseling; health education of the general public regarding problems of growing old; programs for early detection of disease; home care programs with medical staff and auxiliary personnel, including the use of general hospitals and clinics; rehabilitation services; special hospitals and institutions for the care and treatment of those with long-term illnesses. These services should be available on a financial basis that would permit proper distribution among all old persons.

The present situation: All facilities and programs which promote good health of people of any age contribute toward health in later years; but a more positive approach on the part of physicians and other medical authorities, as well as on the part of individual persons themselves, is essential if our added years are to be free from unnecessary disabilities. There is little at present in the way of programs specifically planned to prevent premature aging.

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

The needs of many older people with medical difficulties can be met more economically and more beneficially by care in their own homes. However, the implementing programs, such as house-keeping services, have not as yet been developed to any significant extent, while medical and nursing care for those with little or no income is often inadequate.

Limited Medical Facilities

The only solution for many elderly disabled people with long term ailments—particularly those living alone—is admission to nonprofit or low cost medical facilities. Unfortunately, such institutions are very limited. Exclusive of facilities for tuberculosis and mental disorders, there are at present in Delaware, Montgomery and Philadelphia Counties six private medical institutions for those with long-term illness. They have a capacity of less than 500 for all ages. Delaware and Montgomery Counties have governmental hospital facilities for 236 elderly legal residents, but Philadelphia has none.

Because of the lack of nonprofit facilities, there has been a mushroom growth of commercially operated nursing and convalescent homes in recent years. There are 44 licensed nursing homes in the three counties with an approved capacity of about 1,400 persons.

In addition there are 75 licensed commercial convalescent homes where no professional nurse is required to be on duty, even though the nearly 2,000 feeble and infirm occupants require medical and nursing care.

Special mention should be made of the needs of the increasing number of aged persons with mental illness. Although there are many mentally ill in the upper age levels in the mental hospitals of the area, there is still not room enough for all who need such care.

Special facilities for the care of the elderly such as the geriatric building and type of service at Norristown State Hospital, are frequently lacking. Also, the use of the institutions to overcapacity is limiting the treatment of many elderly patients who might, with intensive treatment, be rehabilitated and returned to their homes.

Rehabilitative Service Nonexistent

Although rehabilitation—both mental and physical—is often feasible for older people, the common community attitude is still prevalent that

chronic illness, decrepitude and mental inelasticity are necessarily synonymous with old age. Due at least in part to this point of view, rehabilitative services for the aged are practically nonexistent.

A project which the Health Division has recently undertaken with Foundation support will hopefully lead to more effective teamwork between local agencies in the field of rehabilitation. The value of such a development lies not only in benefit to the older person, but also to the community, since data from the Bureau of Rehabilitation and other sources have demonstrated that the production of people put back to work greatly exceeds the cost of their rehabilitation.

Statement¹ of

DR. DAVID A. YOUNG

Raleigh, N. C.

SENILE PROBLEM, ITS RELATIONSHIP TO MENTAL INSTITUTIONS IN NORTH CAROLINA

I think there are numerous compensations in old age, and I would just like to tell one story which might bring that point out.

Since we happen to be in a church community, the story came to my mind of the minister who was talking about the subject of hating people, and enemies, and he said he thought it was rather to be expected that everyone would have enemies. He said that he would like to have anyone stand up who did not have any enemies.

Nobody stood up except one old gentleman, about 96 years old. And the preacher said, "Well, that certainly is fine, to think of a person who has lived to be 96 years old and has never made any enemies and does not have any enemies." He said, "How do you account for that?"

The old man said, "Well, I outlived them, Reverend, I outlived them."

This is perhaps one of the compensations of old age, in outliving one's enemies.

I think that Dr. Johnson has already impressed on you the extent of the problem, the fact that the age to which people live now has increased in the past 50 years from 49 years to something like 66 years, as the expectancy of life. At the present

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

time, we have perhaps one in eight people who is over the age of 65. In 1970, it is expected to be one in 14, and then one in 10. So about 1980, we expect it to be one in 10.

This is going to create a considerable burden on the other people in the world, the workers, so-called, and particularly on old people, because the incidence of mental illness in this group is considerably higher. Within the State hospitals, as big as the number of admissions of people over the age of 65 is, it has increased from around 15 percent to around 25 percent, and in one hospital it is 28 percent.

Those are rather high, I think, in one respect in that perhaps they are lower in this State than they are in other States, but it shows the very definite trend in the direction of trying to hospitalize more and more of the old people, and also the fact that a good many of those do not need hospitalization, although many of them do.

Value of State Institution Questioned

One of the points I would like to make about that, though, is that there is a considerable question in our minds as to whether or not the State hospital is the proper place for most of these old people. We recognize that in a minority, some type of State hospitals, some type of institutional care, can be expected and must be provided. We also recognize that a great many of these people are sent to us who could possibly have been taken care of in some other way.

One of the reasons that this has impressed itself upon us is that we have followed in some instances the course of these old people who have been sent to us. We find, for instance, that perhaps the group divides itself into two. There is a considerable number of these old people who do not transplant readily and who cannot be brought over from their own home environment in the family circles, to which Dr. Murdoch made reference, and placed in an entirely different atmosphere.

I think we can all recognize that as we do a little bit of aging at our own age, we are not becoming less set in our habits; we are becoming more so. And one of the things which is characteristic of old age is the fact that a person gets, as they say, "set in his ways." He does not transplant easily. Therefore, the change in taking him from his own environment, even if he is not get-

ting along well there, to the State hospital, which has large wards instead of small rooms, which has rules which must be followed, which has a certain amount, whether we like it or not, of impersonality about it, that does not prove to be the most satisfactory type of environment in which these people can be cared for.

Transplanting Unfavorable to Adjustment

We find as a result of that, that a considerable number of these do not survive the period of transplanting. In other words, they come to the State hospital and within a reasonably short period of time—that is, within a month, three months, or something of that sort—a considerable number of these group have died.

We also find that those who transplant to that extent somehow or other make a different adjustment. Many of them do not readjust to the point of going out to their homes, but continue in the hospital for a considerable period of time, and create a problem for the State hospital.

I would like to impress upon you, however, that the matter of the proper care of these people, whether it be in a State hospital or not, is our primary purpose. We do find, however, that it does present an additional problem to have this group with us when we have our hands already pretty well full. We find that a considerable number of these live on for a matter of 5, 8, or 10 years.

Now, what can be done about these lies perhaps in a number of different areas rather than a purely medical area. Within that medical area, I must say, as I pointed out, that a certain number of these probably should be cared for in a State hospital.

Geriatric Unit

What comes to us, then, is to provide in the State hospital a proper place for this group. There has been a considerable development in a number of States of the geriatric unit in State hospitals, and certainly a type of building which is somewhat different which generally provides for 1-story buildings with smaller units for nursing care, and with a considerable amount of nursing care for those who are psychotic and in need of care. This nursing care is a very considerable advantage.

* * * It is my impression that one of the reasons why the State hospital gets so many of

these senile people is, not that they are psychotic, but because the State hospital represents the type of State care which is available or which may be available, whereas the State does not provide a particular hospital for the seniles. Perhaps the fact that there was not so much of a senile problem earlier is the reason that the State was never called upon to do that. But it does mean that a State hospital is called upon to hospitalize a person who is not psychotic, but who is showing physical difficulties and who could more properly be cared for in a general type of hospital.

I am sure that a number of people who are connected with general hospitals will immediately disclaim that statement and say that that is not proper because that is not a good place for a person. I do not think it is necessarily a general hospital. I think that some special hospital for the older people may sometime or other become the answer.

That is only for a part of the group. We find that a great many of these who are not in need either of particular physical care or do not have serious chronic diseases, but are showing some of the effects of senescence—the mature senescence, we might say—we find they are in need of a care that will be more of the nature of a boarding home or a nursing home, or something of that sort.

Passing of County Home

We regret the passing of the county home, in the sense that they would like to have seen something better come out of it and still remain a county home, which is a local area available to the old people so that they can be cared for. Of course, in the case of anything after it has existed for a time, it takes on a particular name, and if it is not a particularly good institution, it acquires a certain sort of feeling about that name. In other words, the poorhouse got a bad name, and it became a county home. And so the county home got a bad name, and we are trying to substitute something else for that.

I think that if we had improved the different institutions—the county home—we would not necessarily have had to deal with the problem of the disfavor which that group of buildings has come into.

We hope that there will be provided throughout the State the type of boarding homes that will be satisfactory for these older people, units which

will take smaller numbers rather than large numbers, where, if not their own family, then a family atmosphere of some sort can be provided. We look on that as one of the ways in which the problems of the senile can be met.

Senility and Its Effects

Those are perhaps the persons who are the worst off so far as senility and its effects are concerned. We would also like to point out that there are a great many people who are entering the stage of older years who could probably be cared for much better if we had some other types of units which would be satisfactory for the older people than the homes that were referred to by Dr. Johnson—those that are run by the State, or by some church organization or some other benevolent organization.

We feel that one of the reasons why the problem of senility has come to be such a serious one is that the local facilities throughout have been unable to meet this problem and have dropped the great burden of it into the lap of the State.

We feel that the work which is to be done lies in the preventive stage, to some extent. We cannot keep people from getting older. We are actually helping them to get older. We are actually helping them to acquire more years. But what can be done is the work of trying to help them in those later years.

Recreation and Counseling Service

The other things which were pointed out by Dr. Johnson and which I would like to emphasize, are the matter of the recreation and counseling services which should be available to this group. At the present time, we do not have them available to any great extent. The number of mental hygiene clinics that are operated by the board of health is comparatively small, and the facilities for out-patient treatment are still far in arrears of what they should be.

As I look out on the group, and as I conclude the few remarks that I had to make, one other thought does come to me, and that is that as I look around, it seems to me that most of the people I see are people who have already worked in health work, who are interested in it already, and I feel that to some extent I am talking already to the faithful, that the people who should be here did not come tonight.

Statement¹ of

MR. THOMAS E. BARBO

Representing the Townsend Club

Minneapolis, Minn.

. . . I could be mistaken on this, but I think you either have to be on relief or have a bundle of money in order to get medical care in these United States.

I honestly think there should be a gap, some method whereby someone who is trying, as myself, from the cradle to the grave, to miss that relief line.

I want to say this: that I am substandard; I

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

THE VETERAN: HIS MEDICAL CARE

Statement¹ of

DR. WILLIAM BROMME

Detroit, Mich.

This is perhaps a unique addition to this series of regional discussions before the President's Commission. It is the matter of care for veterans. I am a veteran of World War II; I am a practicing physician; I am a consultant in urology to the Veterans Administration Hospital at Dearborn, Mich., and I have been since its inception, the chairman of the veterans home town care program advisory committee which has supervised this program in the State of Michigan.

At the close of World War II, the Detroit Regional Office of the Veterans Administration was faced with the problem of reducing a huge backlog of scheduled examinations for compensation purposes, and to provide out-patient treatments for a greater number of veterans with service-connected disabilities than had ever heretofore been necessary.

Demobilization of the Armed Forces was in full swing, hundreds and thousands of veterans were being discharged daily to civilian life. Many of these veterans still suffered from battle injuries and disease and would require medical care.

Under laws passed by the United States Congress it is the Government's responsibility to pro-

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

cannot get a hospital policy. At the time I got sick I had not bought one, because the amount of coverage they give you would not have done me much good. It would have covered a certain amount of it, and maybe slapped you off, but we certainly are going to have to cover substandard risks. Everybody else is covered—the children, and the relief people, and everybody and his brother, except those who are trying to pay their way through life, and they are going to have to have some coverage, some substandard ones, with whatever plan it may be, or they are going to have to have some coverage some place so that there is a limit to their expenditures each year for their medical care in order, as I say, to get to that grave without getting on relief.

vide this medical care. This was the problem which the Detroit regional office manager discussed with representatives of the medical profession.

Doctors Pooled in Shortage

After many conferences a plan was conceived which would provide a pool of doctors—without attempting to create a super clinic in the face of a shortage of medical manpower—to take care of the veterans throughout the State. Plans were set up to use Michigan Medical Service, the nonprofit, prepayment health care plan sponsored by the doctors of Michigan, which was already a significant bulwark against the cost of medical care, to act as an intermediary between the doctors and the Veterans Administration.

A fee schedule acceptable to both the Veterans Administration and the practicing physicians was developed. The "Michigan uniform fee schedule for governmental agencies," which had been prepared at an earlier time through a State-wide survey, was the schedule agreed upon for this program.

The second step was to secure sufficient physician participation to make available an adequate geographical distribution of doctors so that veterans in all communities in the State would be properly served. This was done by submitting the proposed program to doctors with the request that they participate. The response was even greater than anticipated. Nearly 100 percent of

the doctors indicated their willingness to participate as "fee basis" physicians in the veterans home town care program.

Program Successful

The program was successful from the very start. As experience was obtained, changes were made in the procedure which reduced paper work and increased efficiency to the extent that the veteran received prompt medical care and the physician reasonably rapid payment.

Currently, between 7,000 and 8,000 veterans are being treated each month by their own family doctors in their own communities. The cost to the Veterans Administration for administering this program by Michigan medical service has averaged 5.43 percent of the amount authorized in the past year. For this cost Michigan medical service prepares the authorizations and reporting forms; sees to it that they get into the hands of the doctors; reviews the reports after services have been rendered; pays the doctors, and bills the Veterans Administration accordingly.

Another interesting point is that authorized visits to the doctors are being reduced by the doctors themselves from between 28 percent and 30 percent each month. This means that the doctors are seeing their veteran patients only as many times as they think it is necessary, and are not using all of the authorizations allowed.

Advantages of the Program

The advantages of this veterans home town care program can be set down as follows:

First, it makes available medical care to all wounded and disabled veterans and provides them with the opportunity of selecting their own physician in their own community. This is an advantage that is not given to veterans in States which do not have similar programs.

As an example, the neighboring State of Illinois has what is called an "agreement" with the doctors of the State to provide medical services on a fee basis.

An examination of the records reveals that during a typical month 602 veterans were treated by private doctors, and 2,421 veterans were treated in the Veterans Administration Clinic, as compared to the Michigan figures for the same month showing 3,486 veterans treated by private doctors, and 1,773 veterans treated by doctors in the Veterans Administration Clinic.

According to the records, Illinois has nearly half a million more veterans than the State of Michigan, and yet in this month they treated a total of 3,023 veterans as compared to Michigan's 5,259 veterans in the same month.

Unless there is a high percentage of physician participation, free choice of doctor cannot be made available, and this situation exists in Illinois where the percentage is less than half. Consequently, the geographical distribution of physicians cannot be such that would permit all eligible veterans to select their own physicians. There can be no question that many veterans in Illinois are being treated by their own private physicians and are paying for this treatment which they otherwise would be entitled to if it were made available to them.

Travel Eliminated

Second, it eliminates the necessity on the part of the veteran to travel from his home to the Veterans' Administration to receive such treatment. And it makes it unnecessary for him to lose time from his employment.

The Detroit Regional Office employs 20 full-time doctors, 24 part-time doctors, and 18 consultants and attending doctors. With this staff they see an average of 3,000 veterans a month for treatment and examinations. It is an excellent staff and the service is of the best quality. However, it is evident that through such an arrangement only those veterans in the Detroit area can avail themselves of the necessary medical care through this clinic. Veterans living outside of the Detroit area could not avail themselves of the Detroit regional clinic without sacrificing time and money for travel. To set up clinics all over the State would obviously be a great and unnecessary expense.

Patient-Physician Relationship Intact

Third, it preserves the patient-physician relationship. This is important to both the patient and the physician.

Fourth, it reduces paper work for the doctor and the Veterans Administration.

Fifth, it has created a substantial savings to the taxpayer by reducing the number of people in the Veterans Administration who were previously employed to carry on this activity.

Sixth, it is operated by the doctors of the State and is guided by an advisory committee made up of doctors. The function of this committee is to see to it that reports are properly made, fees are

in line with the services rendered, and that progress is shown in the treatment files.

We feel that out-patient service to the eligible veteran is of the highest quality and that all eligible veterans can avail themselves of the opportunity to receive it.

Lack of Hospital Care

There is, however, a lack of the proper type of hospital care for veterans. I would like to cite the installations which are in existence today, namely:

1. Dearborn, with a total of 1,028 beds, 807 of which are in use, and of these 596 are for general medical or surgical care, 87 for tuberculosis, and 124 for neuropsychiatric.

2. Fort Custer, which has a total of 2,056 beds, 1,969 of which are in use, 11 of these are general medical and surgical, 31 tuberculosis, and 1,927 neuropsychiatric.

3. Iron Mountain has a total of 185 beds, of which 125 are in use. Of these, 117 are general medical and surgical, 1 tuberculosis, and 7 neuropsychiatric.

4. Saginaw has a total of 190 beds, with 167 in use, of which 164 are general medical and surgical, 1 tuberculosis, and 2 neuropsychiatric.

There is also a proposed 500-bed hospital which will be located at Ann Arbor for general medical and surgical care.

It is common knowledge to all interested people that the staffing of these hospitals has been, and continues to be, a problem; and for this reason all of the available beds cannot be used. In spite of this fact, plans are still being made to build additional hospitals.

It is also known that the majority of the patients in these hospitals do not have service-connected disabilities. There has been, and continues to be, a shortage of beds for tuberculosis and neuropsychiatric patients, and yet the last two hospitals opened in Michigan were built primarily for general medical and surgical use, and the Veterans Administration is planning an additional 500-bed hospital in this same category.

We in Michigan are proud of our veterans home town care program and of the fact that it was the first of its kind and one of the leaders in this type of health service.

Shortage of Funds

Moreover, we are faced with the curious problem which arises when Congress fails to be consistent. It is Congress which sets up the criteria by which

a veteran is adjudged eligible for benefit. It is also Congress which allots the funds in payment of these benefits.

But the situation arises when there are more authorized needs than there are funds available in satisfaction of these. Someone is going to have to tell those of us to whom the medical care of the veteran is entrusted how we are to resolve this situation. Are we to treat a part of a veteran? Are we to provide treatment to one veteran and not to the next? We may have to ask this same legislative muddled mind to resolve the problem by the publication of a formula or a list of veterans who shall be denied the rights to which they have been granted assistance.

Disabled veterans in Michigan are being served well by their family doctors. In the six years during which the veterans home town care program has been in existence, over a half million authorizations for medical care have been issued and many veterans have been restored to good health. This was made possible only because of the strong desire on the part of the doctors of Michigan to support a program in the interests of efficiency, economy, and the best possible medical service to the veteran.

Commissioner RUSSEL V. LEE. Are these patients you are caring for service-connected or non-service connected?

Dr. BROMME. Those who are available to veterans home town care or clinic care are service-connected.

Commissioner LEE. They do not take care of any nonservice connected under your program?

Dr. BROMME. We follow the mandate of Congress.

Commissioner LEE. The law says it will give service-connected care and nonservice connected care if the veteran is indigent.

Dr. BROMME. That is correct.

Commissioner LEE. Do you hospitalize these patients?

Dr. BROMME. If there is indication for it we have the ability to hospitalize in the community; yes, sir.

Commissioner LEE. In a community hospital?

Dr. BROMME. Yes, sir.

Commissioner LEE. That is paid for, too?

Dr. BROMME. Yes.

Commissioner LEE. What would you think of taking care of all veterans except the neuropsychiatric and the senile that way?

Dr. BROMME. I would be agreeable.

Commissioner LEE. Do you think that it will work?

Dr. BROMME. Anything that will give good care to veterans is what I am for.

Attitude of Veterans Organizations

Commissioner LEE. What has been the attitude of the veterans organizations toward this program?

Dr. BROMME. We have had the greatest amount of cooperation, sir. We sit regularly with them and we receive their complaints and we file actions against them.

Commissioner LEE. This matter was thoroughly threshed over in a panel not long ago in Washington in which the representatives of all principal veterans organizations were present, and it did not evoke any particular enthusiasm among the veterans organizations. They seemed to want more veterans hospitals under governmental hospital system.

I just wondered if you had encountered any of that kind of opposition?

Dr. BROMME. No, sir. I think I would say just the reverse. I think that they have been very happy with this service and on occasion we have needed their help in other relationships and we have had it 100 percent.

Commissioner LEE. It looks completely likely that in the course of time all the present veterans hospitals will be occupied by senile veterans. That is coming sooner or later.

Dr. BROMME. Yes, I think in the near future.

General Care

Commissioner LEE. So if we are going to give general care, it will have to be done some other way; either build more hospitals or take care of them in the community hospitals.

Dr. BROMME. There is a limit to which there is available trained personnel for staffing, professional and nonprofessional.

Commissioner LEE. Can you give the Commission figures to show that that is cheaper than the ordinary veterans care in veterans clinics and veterans hospitals? That would be a very important thing; it would be an important statement if it could be substantiated.

Dr. BROMME. I think I can amplify that. I do not have the figures at hand. I would require some assistance from Veterans Administration's files, but I am sure that the experience of most veterans who have been hospitalized in veterans hospitals is that it is extremely difficult to ever get out, to find an end point. The pressure in the general hospital in the community is such that when medical care has reached that point where discharge or transfer to home is feasible, that is accomplished so as not to overutilize the beds available. That is not necessary in a veterans hospital.

Commissioner LEE. The incentive for it is not there. If you have those figures, I am sure the Commission would like very much to have them.

Dr. BROMME. May I implement that for you, sir, in a subsequent brief.

Commissioner LEE. Very well.

THE MIGRANT WORKER AND HIS HEALTH NEEDS

Statement ¹ of

JAMES A. SWOMLEY

Executive Director

North Dakota Tuberculosis and

Health Association

Bismarck, N. Dak.

I would like to take this opportunity to present a few facts and observations as they pertain to the problems of the migrant worker in North Dakota, but the needs which they portray are commonly shared by many of our 48 States.

Before I proceed, I should like to define more clearly the substance of my remarks. "Migrant worker" is a loose and rather all-inclusive term. In this discussion, I will ignore the term's broader implications and concern myself specifically with the Mexican-American migrant worker.

In recent decades, the one crop economy of the upper great plains region has been altered through the introduction of the sugar beet and the potato. These crops require an abundance of cheap labor. In recent years the resident population of North Dakota and her neighboring States has failed to fill the labor requirements of the beet and potato farmers. Consequently, these farmers have found it necessary to recruit Mexican-American laborers

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

in Texas and transport them to the Northern Great Plains States.

In the current year approximately 5,000 workers were transported to the Red River Valley by the American Crystal Sugar Co. These workers were then dispersed to farms throughout the Valley, where they were employed by individual farmers. The majority of these workers—men, women and children—were crowded into trucks like so many cattle, and hauled from Texas to the Red River Valley. The Holly Sugar Co. has made some use of air transportation in its recruitment program.

In addition to those workers and their families who migrated under the auspices of the above mentioned companies, an unknown number of workers and their families came north at their own expense or at the expense of individual farmers.

For the most part these workers are American citizens, many are technically residents of Texas, although a considerable portion of their time is spent outside of Texas.

Most of these workers spend 2 to 4 months in areas of beet production, after which there are a number of smaller migrations. Some return to Texas, others move into the nearby potato fields, a few go on to the west coast, and others go to Wisconsin, Michigan, Minnesota, and Iowa. Gradually the majority return to Texas, only to begin a new migration the following spring.

A Pathetic Lot at Best

Realizing the dangers of generalization, I should like to emphasize that these workers are at best a pathetic lot. Their children receive little or no education; their living quarters are commonly called shacks—frequently overcrowded, and usually lacking in sanitary facilities. Their knowledge of good health practices is next to nothing; medical care is meager and sometimes nonexistent; many cannot speak the English language. Few know permanent status in any community. It is indeed rare for a community to recognize any responsibility toward the health, education, or welfare of these workers.

Events of recent weeks in North Dakota have brought to light certain unpleasant realities. The migrant workers have communicable disease rates appreciably above those of the general population. Experience over a period of years gives us reason to believe that we may expect 7 to 10 active cases of tuberculosis in each 1,000 migrant workers.

With an estimated 5,000 workers in the Red River Valley for 1952, we might assume the presence of between 35 and 50 undetected cases of active tuberculosis. These active cases of tuberculosis prove a source of infection to fellow workers, to employers, to children, to anyone with whom they may have contact, and yet this situation has been ignored. There has been no systematic effort to screen these workers, either at points of recruitment or upon their entrance into North Dakota and Minnesota.

TB Cases Dumped at Border

Occasionally, by chance, migrant workers have been found to have tuberculosis. The accepted procedure in handling these cases has been to load the infected individuals—who, I might add, are gravely in need of hospital care—on a truck, haul them to Texas and dump them off. This situation was accurately reported in the *Fargo Forum* of July 27, 1952.

Most of us recognize that to deny diseased persons medical care is morally indefensible; to permit them to spread their infection to others is criminal negligence. Who is responsible?—that is the crux of the problem. And apparently no one is responsible.

Now this isn't a problem peculiar to North Dakota. It's a frequent occurrence in at least one other State. The farmer, the sugar company, the county, and the State all deny responsibility when a migrant worker is in need of medical care, whether it be tuberculosis, injury by accident, or some other disease. The same is true of education.

Worker Lacks Residency

In most situations involving medical care for migrant workers, the worker lacks residency; consequently, units of the Government are unwilling to assume responsibility. For the most part, it would appear that these difficulties might be amended through State legislation.

In the field of communicable diseases, it is essential that the State, local units of government, sugar companies, farmers, and private health agencies work together to establish case-finding programs. It is also essential that steps be taken to provide for the immediate isolation and hospitalization of tuberculosis and other communicable disease cases in the State where first diagnosed.

Where out-of-State residency is established, it may then prove feasible to transfer the patient

when—and only when—adequate medical care is assured. In North Dakota a number of agencies are working to achieve this goal.

Legislation Coverage Inadequate

Speaking as an individual, I believe that the Federal Government could materially aid these States by providing grant-in-aid funds for well-defined projects in communicable disease case-finding among migrant workers, as well as Federal assistance through existing State agencies for their hospitalization and medical care.

It is quite apparent that Federal labor legislation does not afford the same protection to the migrant farm laborer that currently applies to workers in other industries. It would appear that an extension of existing labor legislation to cover migrant farm workers would do much to alleviate the present problem.

Statement¹ of

MRS. I. H. TEILMAN

Rural Health and Education

Committee, Fresno County

Selma, Calif.

As the past chairman of the Health Division of the Fresno County Health Council for some 4 years, I had an opportunity to observe one of our great unmet health needs in our area—the San Joaquin Valley.

This valley is some 250 miles long by about 100 miles wide. It is agriculturally dependent upon seasonal labor for their crops. Cotton is grown quite extensively in the eight counties in the valley. Fresno County is the one that I happen to know the best, being my own home county. It is composed of 3½ million acres, and is larger than the State of Massachusetts.

I was told just recently by the State Department of Unemployment in Fresno that we would need 67,000 hand pickers to pick our cotton crop in the fall * * * about 50 percent of these hand pickers are temporary or migratory people. Fresno County is the largest cotton producing county in the United States.

We have observed that the health and education status of these migratory people is particularly poor. There are perhaps several reasons that cause this poor health condition.

First, I would say that it is due to lack of services in the States from which these people have come.

Second, it is economic. There has been no study made of their actual income. It has been estimated per family per year. Of course, it varies. But it is not adequate to pay for health services.

The living pattern of these people preclude proper health. They are constantly on the move. They have no tie with the health department or with the family doctor.

Inaccessibility of Health Service

And lastly, we might say is the inaccessibility of services. Most of the cotton is grown on the west side of the valley where there are very few settlements or communities, and practically no services are available. It means at least an hour's driving time to the county hospital, where they have to sit in line and wait for hours to get service, and that has meant that we have had many deaths from diarrhea.

Last year our County Hospital Administrator said that it cost Fresno County \$60,000 for hospitalization of infant diarrhea cases. And that was estimated as a conservative \$10 a day for hospitalization.

Schools Need Special Health Programs

These people have certain definite needs that are not met. They need, first of all, health education. And this can be provided in many ways. The schools need special programs in health, particularly in nutrition. Specially trained health educators should be provided by the Health Department to go out into this area to help these people. We need child health conferences in all the camps which are accessible to these people, where they cannot alone have their children immunized but can also receive health education.

We need a staff of home advisers connected with our agricultural extension department who can teach more nutrition and better home methods, which frequently affects health, of course. We need child care centers. That is another one of our great needs, because these children are taken out in cars, locked in cars, or left in the dirt.

Parent education of course can go with a child health center. They need medical care. It has been found that most of the women in that area have a hemoglobin count of about 40. We need prenatal clinics. We need dental care. I could

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

go into many, many other fields, but that is just briefly some of them.

Rural Health and Education Committee

Our health division of the coordinating council observed these particular needs a few years ago and decided to do something about it. As an organization the health division does not act, we simply see that other agencies carry on. And as a consequence this rural health and education committee were formed. It is composed of interested citizens of the community, as some of the large growers, as some of the laborers out in the camps, some of the various health and welfare agencies.

As a result of this, a year ago this fall our project was started. We have eight medical care clinics which are held at night because that is when they can come in without losing time from work. We have six prenatal clinics. These are staffed by our local Fresno County Medical Society. We have four health centers, with the child health conference held there. We have one child care center, which as I am told is one of the finest in the State. We are hoping to have more.

We have to start part-time workers and one full-time worker with the Agricultural Extension, which is trying to train these people in better food habits, in making better use of their foods in an economical way.

The Red Cross has had classes in home nursing and mother-baby care. They have had classes in first aid and safety training.

Mental Health Services

We have a church group in Fresno that have been providing some mental health services. They have been providing recreation, not the kind that is handed out on a platter, but they are trying to show these people how to provide their own recreation. They have organized youth groups, junior choirs, and such.

We feel that this has been a successful venture. We are starting on a second year. * * * The administrator of the County Hospital said that he had the lowest occupancy of his pediatric ward in this time of year of any time yet. Our health officer said that he had the lowest incidence of communicable diseases—that he had not had a single case of diptheria since last January 1. The director of Public Health Nurses said that there were few cases of infant diarrhea, particularly in the families that used the child health conferences.

Greatest Gain in Changed Attitude

The director of Agricultural Extension said that he felt that the greatest gain had been in the change in attitude of the people. They are, as you know, an antisocial group. While they live in groups, their whole lives are centered in their family. And he said he felt that these people are realizing that the people of the community want to help.

It has taken a lot of time and thought to try to work with these people, because they are afraid, they are fearful. One of the ways it has been accomplished is to go into the camps and pick out the potential women leaders and have them form a health committee. They in turn go to the other women and see that the children are brought in for immunization and for the clinics. It is a camp health committee.

The Red Cross, in evaluating the situation, said that they felt the greatest benefit was the fact that public-minded citizens in the health and welfare agencies were working together. Dr. Audrey Gates, who is the Field Director of the American Medical Association Committee on Rural Health, had observed conditions there before the project and afterwards, and he said recently he thought that it was the finest thing of its kind in the country, and that the children were particular beneficiaries.

Moral and Spiritual Health Improved

This project has been the result of a lot of work and thought. The project has improved not alone physical health but moral and spiritual health. It has been typified by changes in the attitude of the people.

Perhaps you want to know how it has been financed, because these things don't operate without finances. Four of our large growers have given the facilities, the health centers, the child welfare center. The actual cash involved for the first year was furnished by the Rosenberg Foundation. It has been their policy to seed a project, to see that it is well started, and to withdraw, with the idea that it will be picked up and carried on. This year half of the budget was furnished by the Rosenberg Foundation.

Since cotton is the last crop of the year these people move into this area, pick the cotton, and stay on during the period of unemployment. Many of

them do not even have State residence, and of course most of them do not have county residence, so that it becomes difficult for the county to take over the responsibility of financing this project.

We do feel that it has been successful, and we would like to find some adequate means for continuing it. It has only covered 4 camps, of which there are around 450 in the county. So you see that there really is great need for extension of it. And of course, we are only one county in this particular area.

**Statement¹ of
MRS. HUBERT WYKOFF, Jr.
Pajaro Valley Health Council
Watsonville, Calif.**

If the migratory agricultural worker and his family have become a special problem in the West, it is because they have been traditionally excluded from the benefits of protective health legislation afforded to the working people of the rest of our population. Their substandard living conditions, it is now recognized, create a health hazard for the whole community.

We ask you, in working out any plan for the health of our country, to be sure that this particular group is included in the plan somewhere.

We cannot expect to have a group of second-class citizens who don't receive the kind of care that the rest of us do, and who constitute a danger in our midst.

* * * Even though many rural problems may be difficult, if not impossible, to solve on a local basis alone, we hope that whatever plan is devised for meeting these needs will allow room for participation of a widely representative body of local citizens in an advisory capacity, on a continuing basis. We have proof of the value of such relationship.

For example, in 1945 my county was sure it could not afford a full-time health officer and an expenditure of more than 35 cents per capita per annum for the Health Department, even though an expert from the California State Tuberculosis Association had come down and made a survey which showed we were woefully lacking in adequate health services. Nobody paid any real attention to his excellent report. It just gathered dust.

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

Health Educator Hired

Then the local TB Association decided to try a new tack. They asked the Rosenberg Foundation to give them the money for a health educator for two years.

This woman understood the way to approach the citizens of a small community and get them interested in finding out about themselves. Before long she had a group of over 100 citizens, making a health survey of the county. The work was divided up into subcommittees on various things, such as milk, food handling, sanitation, child health, and labor camps.

Each committee looked up the ordinances and laws, and tried to find out if they were enforced. They discovered a multitude of health needs and discussed them with their neighbors and soon had the press interested in reporting stories on every topic. The whole community had a year of intensive health education, and at the end of that time the feeling was so strong that the supervisors dusted off the expert's report, raised the contribution for health from 35 cents to \$1 per capita, and put on a full-time health officer and launched a greatly improved program of health services.

Permanent Health Council Formed

The original group of citizens who made the survey formed themselves into a permanent health council, or health committee, and have been meeting regularly for the past 6 years, keeping a close watch on health services and studying ways of improving them. They have enlisted many volunteers to supplement and make more efficient the work of doctors and nurses. They have uncovered private resources for providing many of the health services not yet assumed by the county. They have finally succeeded in developing a harmonious and cooperative relationship between the County Medical Society and the Health Department. They have exercised much ingenuity and thought in trying to improve the quality and efficiency of the work of all agencies, both public and private, to do a better job in protecting the health of the citizens of the county.

They launched a casework committee, composed of the local professional workers in the health, welfare, school, police, district attorney, juvenile court, and mental hygiene departments, and a representative of the County Medical Society. This committee meets regularly, to discuss sample problem cases, and has developed a fine teamwork re-

lationship, a better understanding of each other's work, and has been able to eliminate much waste motion in the form of duplicating visits and interviews. The quality of each agency's service is much improved.

Value of Lay Citizen

Though many of you are doctors on this Commission, we hope you will not forget the value of the lay citizen in obtaining support and understanding for any good health program, private or public. This is most valuable on the local level,

where the final results of any plan are felt. It applies particularly to rural areas, where you need a maximum of local ingenuity and initiative in overcoming difficulties peculiar to that area, such as seasonal fluctuation of population, transportation problems, decentralization, etc.

We believe that the Federal-State-County Governments should help solve health problems that are too great for private hands, but we feel that local initiative must not be snuffed out in the process. It is a matter of building on a solid foundation.

SPECIAL POPULATION GROUPS—THE PROBLEM OF DISCRIMINATION IN MEDICINE

Statement¹ of

HENRY VON AVERY

Director

Community Organization Department

Urban League of St. Louis

St. Louis, Mo.

I am director of the Community Organization Department, Urban League of St. Louis, a social work agency, a member of the Community Chest, and also a member of the Social Planning Council. Any consideration of the health needs of the nation must consider total health needs. The needs of the Negro citizen cannot be ignored.

We shall confine our statements to health needs of St. Louis Negroes and the adequacy of local public health units to meet these needs, to the degree to which other hospitals and clinics meet existing needs and the extent to which Negroes can afford adequate medical care.

St. Louis city has a population of 856,796 and of this number 154,448 are Negroes. St. Louis city and county has 43 hospitals of which 29 are general hospitals; 3 for the chronically ill, 3 are maternity hospitals, 6 for the mentally ill, and 2 serve tuberculars.

Lack of Hospital Beds for Negroes

Of the 29 general hospitals only 16 admit Negroes and of the 16 that do accept Negroes, only 7 admit Negroes on an unsegregated basis. There is a total of 8,307 beds available in municipal, State

and Federal hospitals in this area and of this number 1,500 are available to Negroes. Yet Negroes constitute more than 18 percent of the total population.

Koch Hospital for tuberculars, operated by the city, has a total of 640 beds of which 224 are segregated for Negro use. The resident tuberculosis rate in 1951 was 70.2 for Negroes and 25.6 for whites. The tuberculosis rate for Negroes is almost three times the white rate, yet only about one-third the total number of beds is allocated to them. The Missouri State Sanitarium, a State institution with 640 beds, has 42 for Negroes. This is inadequacy at its worst. There is a private hospital for tuberculars, Mt. St. Rose, which does not admit Negroes.

Municipal Facilities for Negroes

Municipal facilities do not meet the needs of Negro indigents. The municipally owned and operated hospital available to Negroes is the Homer G. Phillips with 711 beds and 49 basins. City hospital, the Starkloff Memorial, accepts Negro patients in a segregated isolation ward that has only 37 beds.

The St. Louis City Infirmary and Infirmary Hospital for the chronically ill has a capacity of 1,512 beds and houses only 312 Negroes in an institution that has been overloaded for three decades. There is need for hospital facilities for the Negro chronically ill.

Then hospitals for the mentally ill are available to St. Louisans, but of the six public institutions designed for such specialized service, only the St.

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

Louis State hospital, with a capacity of 3,500 beds, of which 430 are segregated for Negro occupancy, takes in the Negro. New Negro admissions take place only on the death or discharge of current inmates. This has caused Homer C. Phillips Hospital to house permanently mental patients when it was designed as a relay station.

Discrimination in Municipal Institution

We have the spectacle in our community of seeing a municipal institution built for psychopathic cases with tax moneys which does not admit Negroes—this is the Malcolm Bliss Psychopathic Institution. Another public hospital, the St. Louis County Hospital, has 216 beds, and 56 are segregated for Negro occupancy.

The Veterans' Hospital in this area has 647 beds, of which 105 are for Negroes.

Fee-charging hospitals admitting Negroes have a total of 2,318 beds, of which 455 are for Negroes. Of 16 private hospitals admitting Negroes, only 5 admit Negroes without segregating them. This means that in many of these institutions the physician of his choice is denied the patient, and he has the added humiliation of discrimination and segregation. Barnes Hospital, with bed space for 435, allocates 45 to 50 beds to Negroes, and most of these patients are confined to a basement ward below street level.

Missouri Pacific Hospital houses a portion of its Negro patients in a basement located near the laundry and kitchen. Medical care has its oddities—the Bernard Skin and Cancer Hospital has 20 beds for white males, 20 beds for white females, and 4 beds for Negro females. The Negro cancer patient is directed to the city's Homer G. Phillips Hospital.

There is need of facilities for the Negro cancer patient, for although the Negro constitutes only one-fifth of the population, the mortality rate for Negroes is 177.5 to a white rate of 185.7. There is no institution for the Negro cancer incurable.

Maternity Hospital Problem

Of three maternity homes in the community, only one, the St. Louis Maternity Hospital, admits Negroes to 22 beds in a 135-bed set-up. The Negro maternity patient, therefore, has to utilize Homer G. Phillips again or St. Mary's Infirmary or Peoples Hospital, all of which are general hospitals.

The Peoples Hospital has only 88 beds and St. Mary's Infirmary 146. The total number of Negro livebirths in 1951 was 5,068 to 14,955 whites.

White stillbirths totaled 283, and Negro stillbirths were 206. Infant deaths among whites was 343 and among Negroes 200. These figures speak of inadequacies.

Public Clinical Services

In public clinical services the city operates five health centers, and they provide dental service for elementary school children. All Negro school children were for years sent to one dental clinic until 1951, when all but one dental clinic—the Wyoming—was made available to Negro school children. The Wyoming is a clinic financed in part by public funds and was completed in 1951.

Dental clinics operated by St. Louis and Washington Universities will extract teeth of Negro patients, but will not fill them or provide bridge-work. The clinical picture is a little brighter than the hospital picture, as 14 clinics out of 22 give some medical services to Negroes unable to pay for medical care.

Services for epileptics total six, of which three, the State institutions, serve Negroes. The three private set-ups do not admit them. Of the four institutions for mental defectives, only two, the State institutions, provide service to Negroes.

St. Louis has 13 hospitals that do not admit Negroes. They have a total of 3,667 beds.

Adequate Care Out of Reach

The extent to which St. Louis Negroes can afford adequate care needs no lengthy exposition. The 1950 census figures on weekly family earnings are not available as yet. However, in 1947 the average weekly earnings of whites in the city and county were \$64 per week and the earnings of Negroes were \$38 per week.

In the past 5 years wage figures may have increased, but the differential has not lessened, while prices of all commodities and even medical services have mounted. This means that a large number of Negroes are not able to afford adequate care.

The needs of the Negro community are more beds for tuberculars, the mentally ill, the maternity case, the cancer patient, the chronically ill, retarded children (facilities for these being almost nil), and dental service for school children who qualify. The death rate for St. Louis in 1951 was 2,148 Negro and 7,802 white. This rate has a significance in terms of inadequacies, true, not only of health facilities, but of other factors, but the fact remains that more adequate facilities would have lowered this rate.

The health standard of St. Louis and St. Louis County can be raised as adequate care is made available to Negroes. This can be helped by abolishing discrimination and segregation in all health facilities, both public and private, and by the opening of hospital and clinic doors that are barred to Negroes.

Statement¹ of MAX MONT

Staff Representative.
Jewish Labor Committee
Los Angeles, Calif.

(The following are sponsors of this report: the Los Angeles Central Labor Council, AFL; the Pacific Southwest Regional Office, Anti-Defamation League, B'Nai B'Rith; the Jewish Labor Committee; the Los Angeles County Committee on Human Relations; the Los Angeles Urban League; International Ladies Garment Workers Union of Los Angeles; and the Los Angeles Chapter, National Association for the Advancement of Colored People; the Los Angeles CIO Industrial Council.)

* * * * *

In common with other civic groups, member organizations of the County Conference on Community Relations, are deeply concerned with the problem of providing adequately for the health needs of all individuals in the community. A particularly critical, and frequently overlooked, aspect of this problem is specifically considered in this statement.

Discrimination Aggravates Existing Needs

Acute as the problem of unsatisfied health needs is for many segments of the community, it is further aggravated and magnified for many racial, religious, and ethnic minority groups by the following factors:

1. A physician's care is less available to minority group persons. Some doctors discourage minority group patients, while the number of Negro, Mexican-American, Oriental, and many other minority group doctors is disproportionately low.

2. Qualified minority group persons encounter racial restrictions when seeking opportunities to enter the health profession and face discrimination in the use of training facilities for doctors and other health personnel.

3. The number of hospital beds available for minority group persons is reduced by various forms of segregation and discrimination practiced in many hospitals.

4. Discrimination against minorities is common in the operation of group health plans.

5. A high proportion of dentists reject minority group patients.

6. Minority group persons must frequently pay consistently higher fees to obtain services equal to those enjoyed by others in the community, when such services are available to them at all.

7. Other forms of social and economic segregation and discrimination—such as housing segregation and its attendant overcrowding—tend to create environmental conditions which drive up the incidence of disease in minority group neighborhoods.

In some fields much progress has been made toward removing this tremendous added burden of health problems imposed upon minority groups. But the general pattern persists—presenting a constant threat to the health of the community as a whole, and wasting the limited financial resources available to public and private health institutions.

A great deal of the evidence of discrimination is presumptive. Doctors, schools and hospitals decline to state in writing their policies on racial discrimination. Organizations in Southern California concerned with promoting better human relations in health and medical programs and institutions, are now endeavoring to ascertain the full facts about the extent of discrimination and to reveal the manifold devices employed to restrict minority groups. Much of the truth has already been learned, however.

Training Facilities

From reports of the findings of such groups as the 1950 conference on discrimination sponsored jointly by the American Council on Education and the Anti-Defamation League, we know that discrimination against students of minority groups is a common Nation-wide practice for medical schools. The report of the conference reads:

The findings corroborate one another at every point where they deal with the same subject, even though the techniques employed in investigation differ markedly both within and among the several studies. Many institutions * * * employ techniques in the admission of students that lend themselves to discriminatory prac-

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

tices. Furthermore, these techniques appear to serve no purpose other than that of discriminating against youth of certain minority groups. Race, religion, and national origin all constitute serious barriers for thousands of qualified youth seeking higher education.

One example of a practice with clear discriminatory implications, is the use by Southern California medical schools of entrance forms containing questions concerning the race and religion of applicants.

On a national scale, the figures released by the American Medical Association (*Journal of AMA*, Sept. 9, 1950) are significant: During the 1949-50 school year, 25,103 students were enrolled in 79 grade A medical schools; 647 were Negroes. Of this small total of Negro students, 513 were students at the 2 national Negro Medical Colleges, Howard University and Meharry Medical College. In the balance of the medical schools, the percentage of admission of Negroes was approximately one-half of 1 percent.

The result in Southern California of these exclusions is reflected in the 1950 Directory of the State of California Board of Medical Examiners, where these figures were given: Of the 6,920 licensed physicians and surgeons in the Los Angeles County only 74 were Negro, 11 Mexican-American, 42 Japanese-American, and 7 Chinese-American. Of the 611 approved internships and residencies in Los Angeles hospitals, only 12 are filled by Negroes or Mexican-Americans.

Findings of Hospital Survey

In a detailed survey by Dale Gardner, conducted for the County Committee on Human Relations (appointed by the Los Angeles County Board of Supervisors), it was clearly indicated that there is a negligible number of hospitals with a representative interracial staff, that only about 13 percent of the hospitals maintain an "open policy" with their staff doctors for admitting all patients referred by these doctors, that the percentage of minorities using hospital facilities was alarmingly small.

The survey also revealed that there was a tendency to place those minority group patients who were admitted in either private rooms or in wards, and that in the case of the latter, 55 out of 85 institutions indicated "they attempted to segregate one or more of the three minority (Negro, Mexican and Oriental) groups in higher priced rooms."

Some institutions indicated that they formerly had segregated Negroes because they were afraid of possible complaints from prejudiced patients. On changing their policy to granting whatever service was available to whatever patient could afford it, they discovered that there were very few protests, that sick people were more interested in the quality of the nursing care than the pigmentation of the skin of the patient in the next bed.

A more recent survey of a representative number of the larger Los Angeles Hospitals was conducted in 1951 by the Anti-Defamation League. Eight hospitals were involved. The survey revealed that these hospitals employed a total of 58 full-time doctors, of which none were Negro and none were Oriental or Mexican-American. Interns and residents totaled 89. None of these were Negro and only three were persons of Mexican-American or Oriental minorities. Staff doctors were 995 in number, of whom only 2 were Negro and 14 Oriental or Mexican-American.

A Chain of Discriminatory Forces

Most important of all were the statistics on physicians who obtained courtesy privileges in the use of hospitals for their patients. Six hundred and eighty-three doctors are extended courtesy privileges. Of these, 2 are Negro and only 12 are of Oriental or Mexican-American descent.

It should be understood that the conditions revealed by these two hospital surveys are not necessarily, in every instance, the result of a deliberate policy of discrimination. Frequently, these conditions are the product of a chain of discriminatory forces at work in the community as a whole. Nevertheless, questions and complaints have been so persistent that the Los Angeles Urban League has decided to arrange for a community-wide study to obtain a complete picture. The staff representative directing work in this field declared:

The Los Angeles Urban League services' requests of the past few years have well emphasized the need for a comprehensive and exhaustive study of hospital services.

Urban League members and friends call our offices making negative remarks about their treatment in "X-hospitals." Others call and express an interest and curiosity about the staff assignment of Negro doctors, the employment of nurses, and the room-service policies. Other persons in their office contacts reflect a satisfactory relationship with "A-hospital" or "B-hospital."

All of these varied comments have led us to the conclusion that a thorough study is a must, and we are now in the process of initiating this approach through the Welfare Council—the over-all community planning body.

Acute Need for Dentists

The need for dentists in the Los Angeles area is becoming particularly acute with the unfortunate combination of the influx of a growing population and a lack of training facilities for dentists in Los Angeles. There is but one dental school, the University of Southern California School of Dentistry. (Here a Negro student is seldom admitted.) While the school graduates approximately 100 dentists a year, a large portion of these are now going directly into the Armed Forces.

Practitioner Restrictions Against Minorities

Among private practitioners, there is flagrant discrimination against Negroes and Oriental patients. Ninety-eight percent of the private practitioners, it is estimated, restrict these minorities in one way or another. One dentist who does accept Negroes and Orientals reported that he had to go outside of the established professional dental society to find a dental surgeon to whom he could refer his patients requiring surgery or extractions. There is also distinct but less pronounced discrimination against Mexican-American patients.

The limited services and facilities available in dental clinics are greatly overcrowded. Long waiting lists are the rule.

Members of minority groups are forced to go outside the organized dental profession and become patients of dentists who are reported to hold much lower professional standards, charge exorbitant fees and exploit their patients in other ways.

This in turn tends to perpetuate the practices of less reputable dentists and renders the community prey to unethical advertising and other devices.

Minority Dependents Ineligible

Discrimination is common in the operation of group health insurance plans. The percentage of Negro or Oriental doctors is fractional and some of the large plans do not include Negro patronage. For example, labor unions which in the past investigated one well-known Los Angeles plan (which has an estimated 200,000 subscribers) were compelled to reject this plan for their members when they discovered that it clearly discriminated against minority groups. Individual application blanks and information booklets of the plan stated "Eligibles: Any person of the Caucasian race between the age of 21 and 50."

The unions reported that this group plan cared for some Negro patients who join the plan as a part of a large group of employees, but dependents of these Negro members are not eligible as are those of Caucasian subscribers. The name of the group plan is omitted here because it is understood that the policy of the group is being altered to eliminate discriminatory admission practices.

Health insurance plans which do not include clinic facilities usually have higher rates for Negroes than for Caucasians of the same age, principally due to the discriminatory policies of the hospitals and the requirements for private rooms, et cetera.

Racial Composition Factor in Rates

In group insurance plans underwritten by private insurance companies, the companies usually consider racial composition as a factor in determining their rates. Thus, a group with a high percentage of Negroes for example, will be charged, generally, higher premium rates than a Caucasian group, unless other conditions exist to offset this factor.

Aside from this, in plans where individuals are compensated for medical or hospital expenses but must find their own accommodations, exorbitant charges and other forms of discrimination result in the minority group person receiving less for his health dollar.

A Program of Cooperation

Protection of the health standards of the whole community, efficient and economical use of health facilities, and removal of the added burden imposed on minority groups by discrimination, requires a program of cooperation among community organizations and public institutions to:

1. Study the facts concerning health, hospital, and medical practices for the purpose of evaluating their adherence to democratic standards;
2. Inform the public of the success achieved by institutions and programs which follow the democratic practice of full and integrated participation by, and selection of, staff and patients;
3. Promote full and equal access to all health, hospital, and medical services by all persons without segregation or discrimination;
4. Encourage the full and integrated utilization of manpower in all research, medical and health programs and institutions on the basis of merit alone, and without regard to race, color, creed or ancestry;

5. Further, the establishment of democratic practices which will give to all qualified persons full and equal access to all health and medical training institutions and facilities;

6. Provide programs designed to educate the public to the need for democratic practices in health and medicine;

7. Institute human relations education programs as part of the training of health and medical personnel dealing with the public.

Roots of Discrimination

Commissioner RUSSEL V. LEE. Mr. Mont, this is not a question, but I want to point out that this matter of discrimination has had a lot of attention by the Commission. One of our members is a Negro. And we find as far as the doctor and the dentist are concerned that the trouble is far down the line.

There are a number of medical schools, notably Cornell, and some others, that have tried to find qualified Negroes to admit, and in spite of the fact that Dr. Hennessey has gone way out of his way, he has had great difficulty in finding enough qualified Negro premedical students who can make the grade when they get in. He strained the point and let some of them in, and they have had a difficult time.

I would call attention to the fact that it is the view of many who have interested themselves in this matter that the difficulty lies further down the line in the preparation of these boys for medical schools. There are unfilled places in the medical schools that could have been filled if good, qualified Negroes had presented themselves.

Mr. MONT. May I comment on that?

Commissioner LEE. Yes, indeed.

Mr. MONT. I think I stated in the record—I will quote that section again:

It should be understood that the conditions revealed by these two hospital surveys are not necessarily in every instance the result of a deliberate policy of discrimination. Frequently these conditions are the product of a chain of discriminatory forces at work in the community as a whole.

Proper Education Unavailable

I think that also holds true on medical schools. However, I think it is clear that it is a product of both things. In part it is a fact that the Negro isn't able to receive proper educational training much before the time comes for him to enter medical school. But on the other hand it is true that medical schools do in very many cases carry on a

practice of discrimination, as indicated by the application forms, for example, in Southern California medical schools, which have questions concerning race, religion, and so on, and which from a survey that we have conducted, seem to have no other purpose than to determine quotas, perhaps.

Compounding Discrimination

Commissioner DEAN A. CLARK. Mr. Mont, may I ask if you have found in your studies, for example, that Negroes do not employ members of their own race?

Mr. MONT. Employ?

Commissioner CLARK. As physicians.

Mr. MONT. That would be difficult to determine. However, the problem generally of obtaining any kind of medical assistance when any kind of doctor is retained by a patient, obviously the patient seeks to get the best possible doctor.

If a patient should think that some doctor, because of discrimination, was unable to receive proper medical training, it may be that that patient would go elsewhere rather than retain that particular doctor.

In addition, if the doctor hasn't got access to hospital privileges, for example, there would be an inclination not to take that doctor because of your own personal needs, a situation which would not hold in the case of majority groups. And in many cases, in fact, because of needing hospital care the Negroes may decide to go to a white doctor, and that further compounds the problem of discrimination.

Statement¹ of

DR. R. E. EARP

North Carolina Rural Leader

HELPING THE NEGRO TENANT FAMILY

Out of my experience as a physician and a farmer-landlord, I submit my views on what can be done toward "Helping the Negro Tenant Family."

In approaching the task of devising and fashioning a remedy, we must first recognize and evaluate the problem: the health inadequacies of the Negro tenant family.

As a physician, I know of no better yardstick to measure the health standards of a group than age-adjusted death rate statistics.

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

The Southern Rural Negro

Applying this time-tested yardstick, we find that the health problem of the southern rural Negro—the Negro tenant farmer, if you please—serious as it is, is not as bad as that of the Negro industrial worker in the North and East.

For instance, the death rate among rural Negroes in the South is 14 per thousand per year, while the death rate among Negroes in the industrial areas of the North and East, in cities of 100,000 or larger population, is 16.6 per thousand per year.

These statistics are presented not to belittle the problem, but rather to illustrate a health pattern too often ignored by misguided and starry-eyed professional do-gooders. Let us consider further these figures, which, incidentally, are the latest available from Census Bureau reports.

The death rate of rural whites in the South is 9.1 per thousand per year, as compared with the Negro rate of 14, while that of white industrial workers in northern and eastern industrial centers is 10.7, as compared with the Negro rate of 16.6.

Yes, we face a serious health problem, particularly among Negroes, and more particularly in the large industrial centers of the Nation, where slum conditions exist.

Illegitimacy as a Factor

Again I speak as a physician and not as a moralist. So long as there continues an alarming 24 percent of all births among urban Negroes that are illegitimate, as compared with a rate of 18 percent of illegitimate births among rural Negroes, the gap between the two groups of population will remain more or less static. Many health facilities are available today to Negroes that they are not utilizing, both in the rural areas and in congested industrial slums.

Good health starts at birth—even long before birth. If the infant, whether it be white or black, is to have the full benefit of health facilities that already exist, there must be a feeling of family responsibility. Such a feeling oftentimes is rather weak and indifferent where illegitimacy is involved.

What is needed is more and more education to develop a more robust concept of family responsibility, to the end that all available health facilities are utilized.

Indifference to Health Needs

Indifference to health needs on the part of both urban and rural Negroes has been further confirmed by spot studies of illness rates and treatments, as between whites and Negroes. One significant fact that emerged was that only three-tenths of 1 percent of Negroes in the study group had their teeth filled during the study year, but that 9.3 percent of whites did.

Among the whites, 4.6 percent sought and received treatment for violent or accidental injuries, but only 1.8 percent of the Negroes received medical or surgical treatment for this cause. And yet, these two groups represented a normal pattern of the over-all population, as is proven by the fact that the pregnancy and childbirth rate ran hand-in-hand, 1.8 percent for whites and 1.6 percent for Negroes.

Economic Status

Recognition, of course, must be given to the fact that economic status or per capita income enters into the problem, and that the rural or tenant farmer Negro and his family are close to the bottom of the column. Slowly but surely this unfavorable unbalance is being wiped out.

The question we face is how can better health standards for the Negro tenant farmer be soundly and most satisfactorily accelerated. The words "compulsion" and "compulsory" are abhorrent to the American way of life.

The American people—all segments of them—can be educated; one of them can long be driven.

To one looking at the question from the viewpoint of both physician and landlord specifically, and as an average American generally, the preferred route seems to me to be over the broad highway of mutual understanding, education and co-operation.

Health and hospitalization insurance purchased by the individual and family head—not given to them—appears to be destined, if encouraged at all levels, to make an important contribution to the solution of this important health need of the Nation.

Education to Responsibility

Encouragement at all levels encompasses: (1) educating the Negro in the selfish benefits that will flow to him and his family from proper medical care; (2) landlords being educated to recognize that a healthy tenant family is more valuable than a sickly one; (3) landlords and extension services

constantly pointing to the benefits of health and hospitalization insurance; and (4) persuasion of companies writing health and hospitalization insurance to send their agents into the rural areas and not just skim the urban cream.

I repeat: "compulsion" and "compulsory" are abhorrent to the American way of life. Let us continue to dot the land with modern hospitals built with Hill-Burton Act funds and State and local moneys. Let's educate all the people to utilize more effectively existing health facilities. Let's educate all the people in the benefits of health and hospitalization insurance, so that they will want to buy and will buy their own health protection.

When we do that, we will be helping ourselves. We will be protecting our own families from the dangers of epidemic diseases. We will be keeping America strong. We will be doing things in the American way, and we will be "Helping the Negro Tenant Family."

Statement¹ of

DR. W. K. FLOWERS, JR.

Dallas, Tex.

We were asked to speak on the problem of Negro health. I couldn't help but—well, it did come to my mind that actually it is a misnomer. Disease is no respecter of racial, religious or even neighborhood border lines. Disease affects the whole community, and its control, prevention and treatment should extend to every individual and every section.

Gains in the health of the general population can be measured in terms of the falling death rate and the decline in certain causes of death, the lowered incidence of communicable diseases, the amount and kind of other illness in the community, life-expectancy estimates, and related facts that are now recorded routinely by physicians and public health officials.

Adequacy of Health Facilities

The adequacy of a community's health facilities and services can likewise be measured in terms of the number of available doctors, nurses, technicians, and other professional workers in proportion to the population, together with the number of beds in hospitals, nursing homes, and institu-

tions for care and treatment of the ill; the number and capacity of diagnostic, preventive and treatment clinics and centers; the amount of laboratory and other analytical or research equipment in use.

It has been found that as a rule minorities do not share equally in the health gains of the general population. The number of hospital beds for Negroes is disproportionately low and grossly inadequate; Negroes and some other minorities do not enjoy equal use of clinics. They are barred from or discriminated against in medical and nursing schools and in professional associations. Even after they complete their training they are often restricted in their basic right to use it. Patients are likewise denied the services of a doctor, nurse, or dentist of their own choosing in those communities which restrict practice in hospitals and clinics.

Health Is Everybody's Business

Health is everybody's business and should be everybody's concern. Each individual and every group can contribute to the solution of common problems, and help meet common dangers that result in sickness, disease and even epidemics. It is actually constructive selfishness and prudent self-protection for individuals, communities and governments to concern themselves about the health of all people, for illness levies a terrific toll, and collects in suffering and in economic losses.

For the past 100 years, Negro life expectancy in the United States has averaged 10 years less than white, and the diseases which show excess rates among Negroes all are classed as preventable. More health education and more adequate facilities are evident necessities. Dallas needs more Negro doctors for its population, more hospital facilities, more graduate Negro nurses.

Tuberculosis Death Rate Among Negroes

For example, the death rate from all causes for the entire country in 1945 was 10.5 per thousand of estimated population. The Chinese, however, had a rate of 12.8; the Negroes, 12.0; the Indians, 12.0; and the Japanese, 11.5. Similarly, many diseases strike minorities much harder than the majority groups.

Tuberculosis accounts for the death of more than twice as many Negroes as whites. Among the Indians in rural United States, the death rate from tuberculosis is more than 10 times as high as that for whites; in Alaska, the native deaths from this cause are over 30 times greater. In Texas,

¹ Delivered at the Regional Hearing in Dallas, Tex., August 18, 1952.

seven Latin-Americans died of tuberculosis for every Anglo-American.

Infant and Maternal Death Rate

Infant deaths furnish another example of this pattern. On a Nation-wide basis, the infant mortality rate was more than half again as high for Negroes as for whites. In Texas, it was almost three times as high for Latin as for Anglo infants.

Maternal deaths show like disproportions. In New York City, where the vast majority of the Puerto Ricans in this country are located, reports from social workers and city health authorities indicate that the frequency of illness among the Puerto Ricans is much higher than among other groups.

Handicap of Unequal Opportunity

As has already been noted, our minorities are seriously handicapped by their economic status. Frequently, because of poverty, they are unable to afford even the minimum of medical care or a diet adequate to build up resistance to disease. The depressed economic status of many of our minorities combined with restrictive covenants in housing prevents them from living in a sanitary, health-giving environment.

Children who are not admitted to clean, healthful playgrounds must find their fun in the crowded, dirty areas in which they are allowed. Discrimination in education withholds from many people the basic information and knowledge so essential to good health.

A more direct cause of unequal opportunity in the field of health is the discriminatory pattern that prevails with respect to medical facilities and personnel. Many hospitals will not admit Negro patients.

The Public Health Service fixes as a satisfactory standard one doctor to each 850 population, one to 1,000 as a minimum. In the United States, there is one Negro doctor to 3,337 Negro people; in the South as a whole, one to 4,913; in Texas, one to 5,569; in Dallas, one to 4,210. Forty percent of all Negro doctors are in 7 Northern States which have only 19 percent of the Nation's Negro population. There are presently 15 Negro doctors in Dallas, 6 Negro dentists, and 16 Negro graduate nurses.

Negro Medical Schools

There are but two Negro medical colleges in the United States—Meharry, at Nashville, Tenn., and

Howard, at Washington, D. C. These colleges can accept approximately 140 students per year and are forced to turn away many more eligible candidates than they can accept. No State in the Union provides a medical college for Negroes.

Only 2.2 percent of the 190,000 physicians in active practice in the United States are Negroes, though Negroes represent about 12 percent of the total population. Twenty-seven other medical schools in 1948 were admitting Negro students, but only 93 were in the 27 schools, as against a total of 502 in the two Negro medical colleges.

Hospital Beds

There are 2.5 hospital beds per 1,000 Negroes in Dallas; 5.65 beds for whites. The Public Health Service estimates a minimum need for 4.5 for each 1,000 population. If this estimate is accepted, Dallas lacks approximately 360 additional hospital beds for Negroes.

Negro doctors are not permitted to practice in Parkland Hospital or any of the other large hospitals. A principal reason given for Dallas' inability to secure additional Negro doctors is a lack of staff privileges in public hospitals in Dallas.

Professional Discrimination

To these handicaps must be added the refusal of some medical societies and many hospitals to admit Negro physicians and internes for practice. Denied the facilities and training which are available to other doctors, Negro members of the profession are often unable to keep abreast of developments in medicine and to qualify as specialists. This discrimination contributes to the state of Negro health.

Now with these facts before us, we ask ourselves what to do about it. The following is a listing of steps, which if taken, will greatly alleviate the existing undesirable conditions:

Measures To Alleviate Conditions

1. That better job opportunities be made available for our minority groups.
2. That better and more adequate housing accommodations be secured.
3. That equal educational opportunities be made an actuality.
4. That Negro doctors be made eligible for membership in State medical societies in States where membership is denied; which in turn would make them eligible for membership in the county medi-

cal societies, by the same token, membership in the A. M. A.

5. That when and if this is done, that Negro physicians be given sufficient staff privileges to enable them to treat their patients in public hospitals.

6. That recognized hospitals institute a training school for Negro nurses, internes and residents.

7. That there be provided in the city-county hospital set-ups additional hospital beds for Negroes; that some private, and semiprivate rooms be provided, for which a charge would be made, thereby allowing the Negro doctor to follow his patient into the hospital, a facility not now available.

8. That local medical and civic agencies lend their support in helping secure additional Negro doctors for Dallas.

Statement ¹ of

DR. ROBERT P. DANIEL

President

Virginia State College

Petersburg, Va.

I shall address my remarks to the theme of this section: "How Can We Improve Hospital and Medical Care for Negro People?"

It is very simple in its analysis, but difficult, of course, in its operation. The first * * * we can improve hospital and medical care for Negro people by increased opportunity for Negro physicians and dentists to be trained and to practice.

* * * * *

It seems to me that the improvement of medical care on the part of the Negroes requires that Negro participants have all of the opportunities of professional growth that are indispensable to good medical practice. And since membership in the American Medical Association is so significant, there should be some opportunities made by which Negroes can qualify for that membership.

Scholarships for Rural Negroes

Also, it would seem to me that we can increase the opportunity for Negro physicians to be trained in the practice by providing scholarships to assist persons who will come back for rural practice, as is being done in some of the Southern States, particularly in the State of Virginia, where I am now located. The State of Virginia provides 10

scholarships for physicians of \$1,000 each and 2 for dentists at \$1,000 each, and 20 for nurses of \$150 or \$200 each, provided these persons commit themselves to practice in a rural area.

This economic advantage could be very significant, therefore, in the matter of training persons for practice in areas of great need.

The second phase, it seems to me, of our answer on how we may improve the hospital and medical care for rural Negro people comes not only, as I said, in the opportunity for training and for association with colleagues and the opportunity of practice, but also by including Negroes in provisions for hospital and medical care by public support.

Provision for Negro Medical Care Omitted

Now, we say a good deal about the fact that all of the people in the community must have good health, but I am not so sure whether we have been diligent in our own endeavor to see that they have the opportunity for good health. It is tragic sometimes to see that either by design or by thoughtlessness there is an omission of provision for Negro medical care. Whether that is the reason, the fact is that there is no provision.

In Virginia, in our medical report of last year, we were pleased to read the statement that there are 30 beds for white children now available for children with rheumatic fever, and this covers their need in Virginia adequately at the present time. Then it says, "There are no facilities for Negro convalescent children."

If the need is adequate for the white children, and is significant for the white children, there ought to be some provision in some way for the Negro children.

Negro Maternal Death Rate Higher

The matter also of the high maternal death rate is a case in point and shows also how provisions of hospitalization improve that situation. For instance, we have observed that although there has been a decrease in the maternal death rate among Negro mothers, in Virginia recently the records indicate that yet there are five times more deaths among Negro mothers than white mothers.

But it truly comes by the facilities provided, as is evidenced by the fact that in Virginia in 1935, for example, the number of Negroes who were born in hospitals was only 5.4 percent of the births. Only 5.4 percent of Negro babies were born in hospitals in 1935. But in 1945, in a 10-year peri-

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

od, the number born in hospitals had increased to 27.6 percent. And a parallel indication shows that the larger opportunity for hospital facilities has made for this improvement, and also a corresponding reduction in the infant mortality of Negro children in Virginia.

I am supporting the assertion that one way to improve the situation is to provide the facilities.

Experimentation—a Challenge in Sharing

We may indicate also that one of the significant ways to improve it is by experimentation. That is a real challenge.

There is a town in Virginia which is proud of its progress in providing hospitalization for all of its citizens. The town is too small and the taxes would be too high to have a completely separate hospital for white and colored. There is one community hospital, and the hospital was arranged in such a way as to reduce the necessity of completely separate beds by flexibility in provisions. I have visited the hospital, and many of you may profit by such a visit.

In a community hospital there in that town, they have it so flexible that they have two hospital operating rooms, or delivery rooms. One is used first by colored and the other is used first by white. But if there is a second case for Negroes, they use the other operating room. Colored persons do not wait until the other operating room is available. If the Negro operating room is unavailable, he uses the second room. And the white person does the same, because the rooms are side by side.

In the case of beds, they start the Negroes in one end of the hall and the whites in the other end of the hall, and there is no regard to color.

In the matter, therefore, of the delivery of babies and the need for a little room for the children during the stage of their early infancy, there is only one room and only one attendant at a given time for both the white and colored babies.

The manager of the hospital indicated that it was an economic factor as the basis for the thing. It has worked so well that there is no issue in that community; and since it has been going on now for several years, it is therefore indicative of providing hospitalization for all communities rather than hospitalization for some and then saying, "Sorry, there is not money sufficient for hospitalization of the others."

I submit that the way to improve the hospital care for Negro people is to make the kind of pro-

vision that provides health care under such arrangements that are sufficient for that community.

Statement¹ of

MRS. GENEVIEVE L. STEEFEL

Chairman

**Mayor's Council of Human Relations
Minneapolis, Minn.**

In 1947 the Minneapolis Mayor's Council on Human Relations, aided by Fisk University, explored, among a number of fields, that of the distribution of health services, and the opportunity for training for health services in Minneapolis. This was a survey of not only the distribution, but the handicaps for minority groups in being able to have access to medical services.

It was found that it is the practice in Minneapolis hospitals, in some cases, to admit Negro and other colored patients to private rooms only. Where their budget will not cover the cost of private rooms, needless to say, they are disbarred by that difference from treatment in private hospitals.

The situation has altered in the 5 years between 1947 to the present, to this degree, that we now have the Mt. Sinai Hospital, which is absolutely nondiscriminatory; and we have also a report from the Minneapolis Hospital Council that it will endeavor to arrange for nondiscriminatory admission to hospital beds in wards and in double rooms for Negroes, Mexicans, Indians, and others of the colored races.

Acceptance of Negro Nurse

One of the problems in the increasing of numbers of nurses was found in the 1947 study, and has been proven since, by reports from the Nurses' Association, to be that while there are some hospitals which clearly indicate that they are willing to accept Negro student nurses, there are still a number of private hospitals with nursing schools which are not listed by the American Nurses' Association as willing to accept Negro or Japanese-American, or Mexican, or Filipino young women for such training.

Needless to say, where such people would be qualified, this is a limitation on the possibility of training additional personnel.

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

Discrimination in Residencies and Internships

Residencies and internships in private hospitals in Minneapolis have been denied in many cases, not only on account of race, but also religions, some hospitals in 1947 frankly stating that Jewish residents and Jewish internes were unwelcome.

This, again, is an area in which the community, the Mayor's Council on Human Relations, and the Hospital Council is now active, and we hope that it will be somewhat improved.

It is necessary, however, to bear in mind the fact that these two things have a good deal to do with the limitation both of personnel and of services.

No Convalescent Homes for Negro

The last point which I wish to make is that in 1947, and insofar as is known to the Mayor's Council on Human Relations to date in 1952, there are no hospitals which are privately run which are known as rest homes, or convalescent homes, or hospitals for the chronically ill, which admit Negro patients or colored patients; and in many cases these hospitals have frankly stated they disbar Jewish patients.

That this is a very severe handicap to the senile and aged of the minority groups I need not underscore for you.

I should like to say that all of our public hospitals—municipal, county and State—have a complete nondiscriminatory policy, insofar as admission and placement of patients is concerned, outpatient services, and also residences and internships.

Statement¹ of

MRS. MADGE JACKSON

**The Urban League of Cleveland
Cleveland, Ohio**

The Urban League appreciates this opportunity to be heard at this important fact-finding session.

We are not advocating socialized medicine as the health plan is sometimes called, but we are pointing out a certain lack in our community.

At this time I wish to give you a very few figures which indicate some of the medical needs for the improvement and protection of the people in the Cleveland community.

With your permission my remarks will be directed toward the Negro minority whose population is 120,000 out of a total of 900,000 in the city of Cleveland.

This is not given in the spirit of condemnation nor with ire, for many groups are discriminated against because of lack of information or misinformation.

There are 2,800 physicians in Cleveland, 60 of whom are Negro doctors—a ratio of about 2,500—or a little less Negroes per Negro physician. Over the country, in all of the 49 integrated medical schools, there are only 164 Negro medical students, which is only about 2 percent of the whole student enrollment.

In the two Negro medical schools in the country there are 540 medical students—283 in Howard University and 257 at Meharry Medical School.

Doctor Shortage for Negroes

For the 15 million Negroes in the United States there are 704 Negro medical students in school at present. There are 200 freshmen, 172 sophomores, 163 juniors, 169 seniors. The Urban League receives repeated reports from Negro citizens that it is most difficult to get a doctor if illness occurs after office hours. If the patient calls on the Medical Association or on physicians, he is asked whether he is white or Negro.

While most physicians are socially minded and give the best service they can, there is still the need for more doctors. Notwithstanding this fact, our records show that the medical schools in Cleveland rarely enroll more than two Negro students per year. Since this happens consistently it indicates a racial quota which ultimately limits medical services to all American citizens.

Medical Student Discrimination

The League also has reports that discrimination positively exists in the selection of medical students. Further, the tuition is \$800 per year plus fees and living expenses. This of course limits the number who can take the training if they are accepted.

With a few exceptions a Negro doctor finds it most difficult to practice in the hospitals, even in Cleveland—and when he does, it is difficult to have his patients accepted in most private hospitals, because in Cleveland patients are segregated in hospitals according to race. That is, because of the high illness rate among Negroes—due to certain social conditions over which they have no

¹ Delivered at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

control—there may be no room in the colored section of the hospital for the patient.

Shortage of Nurses

There is a shortage of nurses—an understatement for which I hope you will pardon me. The most recent estimate shows the Nation can use 50,000 nurses now.

Notwithstanding, many hospitals in Cleveland have no Negro student nurses although they are occasionally available.

Those hospitals which are considering the idea of accepting these Negro students insist that they must have two Negro students to enter into training at one time for one Negro student alone would be lonely.

Could the United States Public Health Service or whoever else is responsible point out to the hospitals that a qualified Negro applicant can stand alone? He needs no special treatment—as does no other American citizen.

Let's train every good applicant to fill the nursing shortage.

Recommendations

In conclusion and in addition to the foregoing statements, may I recommend:

(1) That some way be provided to educate more medical students at less cost.

(2) That hospitals work on the question of integrated facilities so that no one will be without care, and that some provision be made to reduce the cost of medical care particularly for the middle and low income groups which cannot get free clinical care.

Commissioner ELIZABETH S. MAGEE. Mrs. Jackson, I was very surprised with respect to what you said about segregation in the hospitals. Is that general?

Mrs. JACKSON. Quite general, Miss Magee.

Commissioner MAGEE. While visiting friends in the hospital I have seen integration in not only wards but in private rooms.

Mrs. JACKSON. In city hospitals patients are very well integrated, and at Mt. Sinai a fine step toward integration has been taken. There is a little lag there but not as great as in some of the other hospitals.

Qualification—Problem in Student Selection

Commissioner RUSSEL V. LEE. Mrs. Jackson, I have been teaching in a medical school for 30 years and have had quite a bit to do with selection of

medical students. Our difficulty as far as Negroes are concerned is the lack of qualified applicants for the places. We would like to take them and are looking for them, but they do not come up. The difficulty seems to be further down the line. We do not have a sufficient number of qualified Negro applicants for medical schools to take in.

We have about a thousand applicants for 60 places, and on the first screening we do not know whether they are white, Negro or what. We occasionally suspect they are Japanese, but otherwise we do not know. Yet we do not find once in 5 years a medical student qualified on the second screening. We do not know what he is at that time.

Dr. Hinsey, of Cornell, reports the same difficulty. They have tried to keep places open for Negro medical scholars and students at Cornell. They have a policy of taking students from all over the country. They have great difficulty in finding Negro students who are qualified to get by the admission department.

I would suggest that the solution or at least some of it has to be farther down the line than at the point of admission to the medical schools. I know several medical schools who would admit more Negro students if they could get them.

Mrs. JACKSON. That is very good to know.

Commissioner LEE. Our experience has been very different. I suggest that you contact our national association in New York. Our Vocational Guidance Department there will be very glad to do some recruiting.

Statement¹ of

DR. WILLIAM SINKLER

Medical Director

Homer G. Phillips Hospital

St. Louis, Mo.

The major health program confronting the Negro population of the City of St. Louis falls into four categories.

First, the medically chronic patients, that is, persons of any age group incapacitated by persistent or recurrent diseases for a period of three months to life, omitting pulmonary tubercular and mental patients.

The second category is pulmonary tuberculosis.

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

The third category is adult psychiatric patients and feeble-minded children.

The fourth is inadequate hospital beds for private Negro patients.

The Chronically Ill

In the first category we admitted to our medical service at the Homer G. Phillips Hospital during last year, 2,950 patients, of which one-third fall into that classification of chronically ill patients, as defined, and another one-third are readmittances to the service. Of this total, approximately 900 patients need custodial care.

During this time there were only 26 patients who received hospitalization at the city hospital for the chronically ill patients. The majority of these patients fall into the old age group, who have recurrent heart disease, cerebral vascular accident, arteriosclerotic peripheral vascular disease, amputees, and so forth.

To my knowledge there are no private homes or hospitals for the chronically ill patients in this community, that is, for Negroes. The problem has grown progressively worse in the last ten years, and with the life expectancy increasing, it is expected that this problem will be even greater as time goes on.

The Problem of Tuberculosis

The second category, pulmonary tuberculosis, is a real problem, inasmuch as the health department and the Tuberculosis Society have increased the tempo of the case findings, while the bed capacity has either been reduced or remained stationary.

During the last year 186 patients were admitted to the tuberculosis ward. Our bed capacity is 30. At the present time there are approximately 15 patients who are on our waiting list for hospitalization, and it has been as high as 35. Out of 186 patients that are admitted to the service, only 86 could be transferred to Koch Hospital.

The others who have been discharged have gone to communities where they are now probably spreading disease.

Increase in Psychiatric Problems

The third category, or the psychiatric patients, is increasing daily, and that has become even more of a problem since the transfer of the city sanitarium to the State. At the present time there are 208 patients in our psychiatric ward. The hospital is equipped to take care of approximately 75

mental patients. During the past year 608 patients were admitted to this service. Out of this group about 36 were transferred to the State hospital, and 24 to the city infirmary. The remaining were discharged back to the community with frequent readmittance to the service.

Some of the special problems and needs of psychiatric services for Negro children in St. Louis are as follows:

Number one, feeble-minded children. Institutions for feeble-minded children are so limited that there is a 2-year gap between the time cases are found and the time they are gotten into the training school. Special schools for the handling of Negro feeble-minded children are completely lacking. As a result, there are many cases in which serious mental defectives are allowed to roam the streets, even when they are a danger to themselves and to others in the community.

Secondly, out-patient for delinquent and neurotic children is available but is quite limited. City clinics do serve this function, but only a small number of the cases are reached in any clinic.

Third, institutional facilities for adolescent children who are mentally ill are practically nonexistent. In many cases, this results in a boy's or girl's having to go into a correctional institution when, if any place were available, this would not be necessary. There are no such facilities where psychiatric treatment can be gotten.

Bed Shortage Acute

The last category, private beds for Negro patients. Out of a population of about 200,000 Negroes, there are only two small hospitals that provide care for private Negro patients. There are two other hospitals with limited facilities for private Negro patients. One of the small Negro hospitals provides for medical care for about one-half of the private patients in East St. Louis, Ill., and the other hospital provides approximately one-fourth. Barnes Hospital has limited facilities for the care of private patients, which is located in an undesirable part of the hospital—the basement.

None of the private hospitals is able to take care of acutely ill medical cases, and many are referred to the city hospital, even though they are able to pay for private care.

This situation, insofar as private beds are concerned, is certainly one which makes the city in-

stitution a haven for patients who can afford private medical care, but they cannot do anything else but go to the city hospital, because emergency beds are not available in the private hospital to Negroes in this city.

The Barnes Hospital has served, and most of them are transferred to the city hospital, and, even though they are able to pay for medical care, this is true.

The same thing is true in private hospitals, where it is seldom that one can get a private emergency bed for Negro patients.

Statement¹ of

MR. GEORGE SCHERMER

Director

**Mayor's Inter-Racial Committee
Detroit, Mich.**

I am here as director of the Mayor's Inter-Racial Committee. I would like to say a word about the nature of the committee itself. It was set up in 1944 after Detroit's very serious race riot of 1943. It is an official agency of the city of Detroit and is supported by appropriations from the city of Detroit.

It is concerned with resolving the problems of racial tension and the practices of discrimination in economic opportunity and in community services. This committee through its years of existence has had many areas of concern.

One of the areas of concern that has become quite important and significant to our committee have been the reports and complaints of discrimination and differentials in treatment based on color in terms of hospital and medical care.

These complaints and reports of differentials in treatments of restricted service of discrimination occurred on these various levels:

In terms of admissions to hospitals, in terms of patient care, of treatment of patients in the hospitals, and in terms of segregation of bed assignments. There were allegations of separate wards allocated to Negro patients only.

In terms of opportunity for training as accorded to nurses, as accorded to young trained physicians wishing to obtain internships and residencies, and also restrictions in opportunity as to staff assignments.

Discrimination in Nursing Training

To be quite specific, the complaints were constantly that Negro girls wishing to train for nursing were restricted in their opportunity to be admitted to nursing schools. Negro young men having completed their medical school training were finding a great deal of difficulty in obtaining internships and residencies in the regular general hospitals set up for training, and that they found restrictions as to the opportunities for trained Negro physicians in getting staff assignments.

Now all of these problems, whether we are talking about medical and hospital service or whether we are talking about employment or housing, are aggravated in communities such as Detroit because of the terrific shift in population which has been going on. In other words, as we attempt to develop programs geared to a population situation at a given time, we find that the ratio of Negroes in our population, for instance, is going up very rapidly in our northern communities.

In the Detroit area, for instance, the total population increase for the 10-year period from 1940 to 1950 was 23 percent. The population increase for whites only was 20 percent. The population increase for Negroes was 100 percent, jumping from 150,000 for Detroit to over 300,000, from 170,000 for the Detroit metropolitan area to substantially over 350,000.

Hospital and Medical Practice

Our committee has not felt competent to evaluate fully the situation in the field of medical and hospital services. We realize that the practices and the problems that beset that field are very complicated, and we did not have people with sufficient knowledge of the field on our committee to permit us to do what we would consider a good sound evaluation. Therefore, last January our committee set up a study committee of representatives from many different areas in the community to study these specific problems of hospital and medical practice so far as the factors of race were involved. We have asked to serve on this committee about 35 people representing, among others, hospital boards of trustees, hospital directors, hospital staff, medical society leadership representatives of the nursing profession, of the training schools and representatives of groups including business, labor, civic, religious and minority group leadership.

Now I regret that this is about as far as I am

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

able to go in my statement here today, because in formulating this committee and getting it started our staff, which is servicing this study committee and the committee itself, entered into an agreement that we would not issue a report on any portion of the study or on any tentative findings until the study is completed and has been properly reviewed by the committee as a whole and approved for release.

Problem Recognized

Therefore I am not in a position today to go any farther than to state that we recognize the problem, that we have got a study under way, and that we have a commitment not to issue any statements of fact until the study is completed.

I would like to read to you briefly the written statement of purpose which our committee presented to this study committee when it got under way.

Survey of Discrimination in Treatment and Training

This is what we say:

In calling this committee together the Mayor's Inter-Racial Committee wishes to make its purposes clear. First we are aware that facilities for care and treatment of the ill in such an area as Detroit rarely catch up with the need and that all people suffer as a consequence. However, the general problem of meeting such needs is not the direct concern or responsibility of the Inter-Racial Committee. The committee has, through the years of its experience, received many reports of differentials in service and in opportunities for training and practice based on color and ancestry or race.

The rather cursory observation of the Inter-Racial Committee would indicate that such differentials do exist, that those facilities which serve the Negro group primarily are below the standards for the community as a whole. It is the proper concern of the Inter-Racial Committee to seek to correct inequities and differentials in service or opportunity wherever they result from differences in color, ancestry or racial background. However, any program for action requires a full knowledge of the problem, comprehensive documentation of the facts and considered advice and recommendations of persons well informed and experienced in matters of this kind. We have therefore invited this group of citizens to help. The committee being organized will be recognized as a committee under the sponsorship of the Inter-Racial Committee. Its assignment will be to survey the field of medical training and service and

the facilities for the care of the ill, assembling and documenting those facts which will indicate the relative existence or nonexistence of differentials in treatment and in opportunities for professional training and practice and the relative adequacies or inadequacies of services and facilities available to the minority group.

Within the framework of this assignment the committee will be autonomous; it will have complete freedom to shape its own policies, to define the scope and form of the study and the contents of such report.

It is understood that the report which it submits will become public information.

In conclusion I would like to say that because this report, once it is finished, will be public information, it will certainly be available to any such agency or group as the President's Commission.

Statement ¹ of

DR. CHARLES S. JOHNSON

President

Fisk University

Member, President's Commission on the Health Needs of the Nation

Throughout this entire program, there has been a very deliberate and planned inclusion of the needs of all of the people of the State in practically all of the presentations.

I would be expected to be especially interested in the Negro population of the State, because it is a large one and it is a rural population, and I was pleased to note that in this evening's program there were two references to the inclusion of the Negro population in the program for mental health.

Considerable Knowledge Indicated

A second observation would be this. The State of North Carolina seems to have taken leadership in the study of the health needs of the people of the State, and these studies do indicate a considerable amount of knowledge about the needs of the people.

That merely stresses the fact that there are needs not only in North Carolina but in our other States that are simply not known, because they can only be known when they have been reached by study or examination. Frequently it is at this level that the persons who were most in need of

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

medical attention are overlooked, and they are likely to be the more numerous.

Those Least Able To Pay

There is a dilemma, too, on which I could say that I got some light this evening. The dilemma has been that the people who, by and large, have been least able to pay for medical attention have also been people who have had the most costly illnesses. Tuberculosis has been one of these. I suppose that I should exclude psychiatry and the cost of psychiatrists from that group.

But the suggestion that came out which was most valuable to me was that perhaps the most inexpensive way of dealing with the very large problem that could require increasing sums for buildings and for medical attention would be through *prevention*. And when one thinks of it, it has been very largely the amount of preventive work that has been developed through the public health programs that has been responsible for the quite remarkable decline that has been noted in the figures for that disease.

Problem of Health Economics

A third observation would be that this conference has not merely been discussing medical needs. It has been discussing health needs. These are not exactly parallel headings. The medical needs can be discussed professionally by competent persons, and that has been done. But then our attention is called also to the fact that not all of the health problem is a matter of medical attention. There is a problem of economics that has been referred to, because if persons are unable to pay for medical attention, they are in a serious way unless it can be provided other ways. And so the economic level becomes important as a part of the health needs.

Then there is the question of education that has been referred to a number of times, because it is a fact that if health facilities are available, unless the people know that they are available and know how to use them, it will be as if these facilities were not available.

Housing

There is the question of housing, because the sociologists and others have been pointing out the direct correlation between inadequate, insufficient housing and the high incidence of morbidity and mortality in certain diseases. There is the question of nutrition. And it has been mentioned in the course of the day that it is not merely a matter of a family's not having certain foods available,

but of a lack of knowledge as to what foods are available or useful to health.

There are other questions of a similar type that might be added which are evidence of health needs that are not strictly medical.

I had one overtone that seemed worth mentioning, an overtone that has to do with words, or fear of words, or ideologies, almost, in the field of medicine. It seemed to me that there might be at one extreme a certain fear of creating a number of shiftless indigents that can tie the hands of many persons who are really concerned—and honestly concerned—with providing critical help to persons who are unable financially to pay for this help.

At the other extreme, it could seem that there is a sufficient fear of destroying the incentive of the private practitioner to hold the hands of those who would like to do something to bring about, let us say, a share in the control of medical indigency.

There is a need for medical personnel which has been developed—and that was impressive because no matter how many hospitals, clinics, and health centers were built, unless there is the personnel to man these institutions they will be useless.

Rural Situation Not Promising

The essential theme for today was rural health, and my general impression, and perhaps I should be corrected on this if I am wrong—my general impression is that the rural situation is not as promising as it might be. The difficulty of getting doctors to practice in rural areas, the difficulty of establishing economic medical units in rural areas, seemed to loom rather large. And although there were presented today some quite extraordinary examples of pioneering in this field, it still seems that the solution for satisfactory medical attention for the rural population has not, as of today, been found.

Statement ¹ of

DR. EUGENE DIBBLE

Medical Director

Tuskegee Institute

Tuskegee, Ala.

I certainly appreciate the opportunity of saying a word or two to this group who are studying the

¹ Delivered at the Regional Hearing in Raleigh, N. C., August 25, 1952.

problem of rural health. I think Dr. Washington used to say when he started Tuskegee Institute in 1881, that he never made a speech above the Potomac River that he could not make in Alabama or the deep South. Certainly it is with the spirit that whatever I say to you today it is with no malice in my heart toward any group of citizens or any section of the country.

I presume you have invited me here to tell you something of the problem of rural health in the area from which I come, based on 30 years of experience as medical director of Tuskegee Institute and as secretary-treasurer of the John E. Andrew Clinical Society that has been in existence now for 40 years. There will be no need for me to discuss with you the disparity between the economic income of Negroes as compared with whites in the South, or the disparity in the matter of housing, or the disparity in the ratio of Negro doctors to the population, or any doctors to the population in the South. You have all those statistics.

Progress Necessitates Cooperation

But the South is moving forward and certainly I am very happy to have some little part in the development of rural health in the South. We are poor people in the South and when we get anything we have to get the cooperation of everybody to help us develop our programs there.

I should say, in Alabama for instance, exclusive of the doctors at the Veterans' Hospital, we have less than 85 Negro doctors in the whole State—I guess less than that now because we cannot replace those that have died in the whole State of Alabama, where we have almost a million Negroes. We need to be training at least 300 Negro doctors a year to take care of the replacements.

Improvements Professionally

I do want to tell you about some of the improvements. The dentists in Alabama admitted Negroes to the Dental Society for 15 years and nothing has happened; and the nurses' association in Alabama 2 years ago admitted them—there is no more Negro Nursing Association. In Opelika we have two Negro doctors who are on the staff and who are on call in that hospital.

If I can get in my County Medical Society, if I can get in the State Medical Society, in the Association, not from the social angle, but from the professional and scientific development, it will be a great step forward.

The Something Valuable

There are a few groups of people who say that the social side is the only thing that keeps the Negro doctors from becoming members of our County Medical Society. They cannot see that the point is if I can belong to my County Medical Society, if I can belong to my State society, if I can belong to the American Medical Association, it helps. If somebody goes to the American Medical Association meeting, if he just goes there and sees the scientific exhibits, he will get something valuable that he can take back to his patients.

That is the thing that we want. That is not a Southern problem. It is a matter just as well in New York as it is in Alabama.

Statement¹ of

DR. R. WILLIAMS

Public Health Service

Bureau of Indian Affairs

Minneapolis, Minn.

MEDICAL AND NURSING CARE FOR THE INDIAN

States To Take Over Indian Care

I am the area Medical Director of the Minneapolis Area, which comprises Minnesota, Wisconsin, Iowa, Michigan, and North Dakota. We are obligated by Congress to get out of the Bureau of Indian Services. In other words, it is going to be up to the States to take care of the Indians, and that is the thing we are working toward right now.

We have four hospitals in Minnesota, one in Wisconsin, and one in North Dakota. We are at the present time negotiating for the taking over the Hayward Indian Hospital at Hayward by the county. That is the way we are going to get out of service. The county will take over the hospital and lease it to some religious organization to take care of the Indians, and the same thing will happen in Minnesota and Iowa. We don't have a hospital in Iowa, but we do have a contract division.

This will throw an added workload on the States. We have between twenty-five and thirty thousand Indians and, as you know, they are in the parts of the State where you don't have many

¹ Delivered at the Regional Hearing in San Francisco, September 2, 1952.

doctors or nurses, and where it is very difficult to keep nurses and doctors.

Problem of Obtaining Medical Services

I wanted to get this over to the people concerned, so that they would look forward to this taking over of the services. We have a tough job, since we cannot give up our services until we make arrangements for adequate service to take care of the Indians, and you can see what a tough job we have in the northern part of this State to get hospitals and doctors to give them hospital service and public health service.

But Congress has said we have to do it. So I am making this known as a need for services for the Indians. Now, we don't intend to pull out and let you people assume the burden. The Federal Government is willing to contract with hospitals and doctors to perform this service, but we are unable to get that service.

I have heard people around here boast about what services they have in other States, but we cannot find the doctors or the hospitals to take care of these people. We are dedicated to that service, and I should think these States should begin to make arrangements to be able to take over this Indian service.

Statement¹ of

HOWARD JETER

East Bay Council of Arts, Sciences, and Professions

Alameda County, Calif.

The question as to the adequacy or inadequacy of our health facilities is one which has many facets and aspects. Each of these must be explored if one is to be able to suggest real solutions to the problems found to exist. The purpose of this report is to bring to the attention of the Commission what the East Bay Council of the Arts, Sciences, and Professions thinks is one of the basic areas for consideration, namely, the problems of discrimination against the Negro people (and other minority groups) as they are related to the general problem to which the Commission is addressing itself.

Discrimination in Alameda County

Our report is based upon a survey done by our organization on the problem of discrimination as

it is practiced in the hospitals of Alameda County, primarily in the cities of Oakland and Berkeley. The survey was done in the spring of this year (1952), and took the form of attempting to obtain from the administrators of some 14 hospitals statements as to the practices of their hospitals with reference to the Negro when he is a member of the medical profession and when he is a patient.

We were able to obtain such statements, either written or verbal, in 7 of the 14 hospitals. Information on the other 7 institutions was obtained from members, or former members, of the staffs of these hospitals.

The specific questions with which the survey concerned itself were those pertaining to the position of the Negro physician in the hospitals; of other medical personnel (nurses, laboratory technicians, medical social workers, etc.); the treatment of the Negro as a patient; and the possibilities of making improvements in any undesirable conditions which might be found to exist.

Position of Negro Physician and Nurse

As regards the position of the Negro physician, the survey found that only 2 of the 14 hospitals for which data was obtained accept or have Negroes on their staffs of residents and internes, while three of the hospitals surveyed have Negro physicians on their attending staff.

As regards the other medical professions, the survey found that 10 of the hospitals had somewhere in excess of 20 Negro nurses on their staffs, while 5 hospitals had Negro nurses employed in supervisory capacities. The problem of the Negro nurse, then, is evidently not that of getting a job—but this is not to say that she has no problem. Her difficulty is that she is the one who tends to get the unpopular work shifts and the most difficult wards.

The Negro as a Patient

With respect to the Negro as a patient in the hospitals of Alameda County, the survey found that there were essentially three kinds of conditions. There are those hospitals which practice no discrimination or segregation (five of the hospitals surveyed fall in this category).

Secondly, there are those hospitals which admit Negroes as patients but which practice segregation (three of the hospitals surveyed fall in this category).

Finally, there are those hospitals which practice a relatively rigid discrimination, admitting no

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 29, 1952.

Negroes as patients (only one hospital falls in this category).

In addition to these classifications there are hospitals which have an official policy of nondiscrimination, but which do not enforce this policy, thus allowing the ward nurse to practice segregation if she desires.

Reservoir of Talent Reduced

As we see it, the facts described above have many far-reaching implications for the general problem which the Commission is studying. Without going into detail, may we simply point out some of the major points which we feel are involved? In the first place, these facts indicate that the reservoir of talent upon which society can draw is significantly reduced. These facts also point up the immediate importance of expanding our present medical facilities, for, if they are inadequate now, they will be even more inadequate when the elimination of discriminatory practices allows all of the people to take full advantage of them. Most important of all, these facts mean that a large section of our population must live in some condition of poor health, which is not only detrimental to the welfare of the groups involved but to society as a whole.

Awareness Fundamental to Evaluation

For the above reasons, as well as many implied if not stated, the East Bay Council of the Arts, Sciences and Professions has come to the conclusion that an awareness of the problem of discrimination against the Negro and other minority groups is fundamental to the proper evaluation of the total situation which the Commission is studying. We therefore make the following recommendations:

1. That all Federal funds and grants-in-aid given with the specific provision that the recipient installation will not practice discrimination or segregation against the Negro people or any other minority group, either as patients or as professional personnel.

2. That all Federal funds given to States, counties and municipalities for medical care and research should contain a similar provision.

We urge the Commission to give full consideration to these and other similar facts and recommendations when it prepares its final report, in the sincere belief that the tax-supported medical institutions should take the lead in removing the blight of discrimination and segregation from the

medical field, and that it is the task of the Federal Government to take whatever steps are needed to begin this process.

Statement¹ of

A. T. SPAULDING

**Carolina Mutual Life Insurance Co.
Durham, N. C.**

I looked at the program . . . "Financing Health for Negro Families." But the more thought I gave to this subject and the problems, the more difficult it has become for me to recognize any material differences in suitable methods or practices of financing health for Negro families from those of financing health for any other families similarly situated, because a hospital will do the same for Negro families that it will do for other families, through Blue Cross, commercial insurance, and all other means of financing.

Needs of Negro Greater

Although this program has three groupings, and sets the Negro apart from the general rural population and the tenant farmer and indigent rural groups, I find it difficult to separate the Negro from the other two groups for our consideration here, and consequently to discuss any program of financing health for Negro families which would not be a repetition of plans and programs already discussed by and for others; for, certainly, in the South the Negro population constitutes a large share of both the rural population and the tenant farmer and indigent rural class.

And I know of very little differences in their needs for medical care, hospital care, and the financing of same, except, perhaps, that the needs of the Negro are greater, and his means of meeting them are less, as has been brought out by previous speakers.

But there is one thing that struck me this morning. I think it was Dr. Hendricks who discussed the matter of what the church might do, because it is in the rural sections where the economic status is lower and where the need is not being touched.

Hospitalization for Rural Negro Lacking

If you will notice the statistics by Dr. Hamilton, in rural areas hospitalization covers no percent of the Negro population. Now, I do not know whether the insurance commissioner might give

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

it some thought, if the laws do not provide it, as to the possibility of, through local church organizations, a hospital care program being arranged, and the citizens of those communities paying those premiums into the organization.

As to the matter of the tenant farmers or the landlords—I think Dr. Earp spoke of the fact that he was both a landlord as well as a physician—as to the possibility of some arrangements being made whereby on a group basis those tenants, with their landlord, might be able to effectuate some kind of group program, because we know that it is too expensive to try to conduct or finance any plan on an individual basis, and certainly the trend toward hospitalization is on a group basis.

Urban Negro Covered

I might say that since the Negro population is not grouped as to rural, but for the entire population, the urban Negro is being pretty well covered by hospitalization. For instance, take my particular company. We have 1,174 employees, all of whom are covered by hospitalization insurance, surgical benefits, medical benefits and hospitalization benefits. And many of the claims that have been filed for hospitalization care have been paid

100 percent. I know of one case that happened just a few weeks ago, where for ten days' hospitalization, the hospital was \$160, and that bill was paid 100 percent by one of our commercial companies.

So you see that it can be done. Then there is another thing. Where you have these employers that are doing it voluntarily and others are negotiating through the labor unions, for the urban group, the Negro populations are being provided to a large extent with hospital benefits.

But it is the rural group where it is needed the most. And if there is a possibility that arrangements can be made on a group basis through voluntary organizations such as these church groups, and through landlords and tenants, some means may be worked out, then the premiums might be paid on an annual basis.

We find that in urban centers, naturally, the practice is to collect things on a weekly or monthly basis. But the farmer, or the tenant farmer, gets his money mostly on an annual basis, and just as he pays for his fertilizer and many other bills on an annual basis, it seems that if arrangements could be made for those premiums to be paid on an annual basis through group methods, this field could be covered to a larger extent.

Part II

PROFESSIONAL GROUPS

DOCTORS SPEAK

Statement¹ of

DR. F. LEE STONE

Illinois State Medical Society
Chicago, Ill.

We have had charges and charges, and now we have charges of money for workers who are having trouble, but still we do not have any shortage of the mentally ill—we do not have any shortage of the geriatric patients. Since I am in that category, I know somewhat whereof I speak.

On behalf of the membership of the Illinois State Medical Society, I acknowledge the Commission's assignment, dated September 18, of a time to appear before the regional hearing which is to be held in Detroit, September 23, 1952.

Concern and Dissatisfaction

At the outset I should report to you that there is a great deal of concern and dissatisfaction, among the 12,000 physicians of Illinois, about the manner in which the Commission has approached its task and then conducted its activities.

Although the Commission was created nearly 9 months ago and will cease to exist on December 29 of this year, it is only now in the process of conducting the hearings and receiving the data and testimony upon which its report presumably will be based. We do not believe a report of much significance or authority can be prepared in the short time remaining to the Commission on the basis of hundreds of 10-minute statements from various persons and organizations.

The officers of the Illinois State Medical Society learned less than three weeks ago that this conference would be held, and that a representative

of the Society might be permitted to testify. The Commission's notice that just 10 minutes had been allotted to us arrived only September 21, 2 days ago.

On short notice such as that, it has been impossible for the officers of the Society to present the matter to the Council, which is its governing body. The other officers and councillors of the Society with whom I have been able to discuss the matter are, as I am, completely at a loss to know how a comprehensive, factual and authentic presentation of the health facilities, accomplishment and needs of eight million people can be prepared in 3 weeks and presented in ten minutes.

Because of the obvious futility of such an effort, we of the Illinois State Medical Society do not propose to attempt it. Instead, we plan to prepare and submit to the Commission, at the earliest possible moment, a report which will do justice to the people of Illinois, and to the physicians, hospitals, nurses and auxiliary health personnel who have created for our State a health record of which all of us are proud.

Commission Initially Criticized

At the time the President's Commission on the Health Needs of the Nation was created, it was severely criticized by many as a sounding board for those both in and out of Government who have labored so long and so zealously for national (compulsory) health insurance. Representatives of the welfare state present their statements in the mornings, when hearing attendance is at its peak. Physicians, nurses and hospital representatives, we are told, are scheduled to appear late in the day, after many of the participants in the hearings have gone. It is our hope that the Commission will in the future find a more effective

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

way of gathering the tremendous volume of information on which its report is to be based.

I am going to qualify that.

Since being here, and being the guest of the Michigan State Medical Society, having contacted the men from Indiana and having read the report from Wisconsin and Minnesota, I realize that there is a tremendous earnestness about this whole thing. And I think it will continue to be that way. . . .

Medical Solutions Difficult

It is felt by many that Illinois has already become the foremost medical center in the world. With its five class A medical schools, its numerous teaching hospitals and its expanding roles in research and in postgraduate medical education, Illinois is justly proud of its position of pre-eminence in the field of medical education.

Our progress in public health, hospital construction, voluntary health insurance, physician placement and rural health is a matter of pride and satisfaction to all of us. But it would take considerably more than 10 minutes to present even the highlights of any one of these subjects. It is for this reason that we propose to file a report with the Commission at a later date.

No Nation, State or community will ever completely solve all of its problems in matters of health, or in any other field, which are so complex. In seeking further improvement, great caution must be exercised that mere change is not mistaken for progress. And, if the cost of health care is to be substantially reduced, the greatest contribution which the Federal government can make is the termination of its inflationary fiscal policies and the confiscatory taxes on which they feed.

Commission's Record Defended

Commissioner WALTER P. REUTHER. I would just like to say this, if I may. We are all in a very good humor, and I think that is the way we should keep it, but I think that the record should be put straight.

To begin with, I think that all of the members of the President's Commission on the Health Needs of the Nation are people of personal integrity, and I do not think that any of them would be willing to serve on this Commission if they thought this was merely a political springboard for the propagation of certain points of view.

I stated at the opening of the session that I believed I was expressing the point of view of all the Commission members when I said we were approaching this very serious human problem with open minds; no one had preconceived pat notions as to exactly how it was going to be done; and that we were trying to get advice and helpful suggestions from people in every phase of the medical problem. And, that out of the wealth of material we were gathering, we hoped to work out a set of practical and sensible and realistic recommendations which will assist the American people, within the framework of the basic freedoms which we are trying to defend, to meet more adequately this problem of their health needs.

I think you should know, in case you do not, that we have had thirty panel hearings in Washington before which there have appeared hundreds of people who were extremely qualified in the many highly specialized areas of the medical problem. There have been more than 6,000 pages of testimony taken in those hearings. In addition, there are being held eight public hearings like this one all over the United States.

Now we have welcomed the participation and the point of view and the recommendations and the suggestions of official spokesmen of the medical society, the AMA. We have tried to get them to actively participate, and I think they have cooperated in many of our projects.

When the Commission was first created a member of the governing board of the AMA, I think, Dr. Gundersen, accepted membership on the Commission, and then some controversy arose. I talked to some doctors, people whom I know, as doctors and as personal friends, and they felt very incensed and were very disturbed that the profession—what they called the men who deal with the political aspects of the medical profession—did not see fit to participate actively, so that their point of view would be represented on the councils of this Commission as it does its day-to-day work. They said to me that they thought the medical profession could make a greater contribution and be better appreciated if it invested in more good will and invested less in Whittaker and Baxter.

You can't solve problems by propaganda contests. You can only solve them by recognizing problems and trying to deal with them as men of good will—and that is the way we have been trying to conduct our hearings. We believe the medical people have a great contribution to make. We

think other people have a great contribution to make. We believe that by coming together in a spirit of good will and trying to explore jointly these very real human problems, that all of us as free people can find a solution and find the areas of agreement that we can work jointly at.

It was in that spirit that we tried to convene this hearing, and I think Dr. Kenneth B. Babcock, the chairman, has conducted this matter magnificently.

Dr. STONE. No question about it. I will say this: That I have had my eyes opened since being here and listening to these people. I have been here since 9 o'clock. These people have stayed here throughout the entire hearing, and of course that speaks for earnestness on the part of everyone concerned. I think that is the most important thing that we have to bear in mind.

Commissioner REUTHER. That is how we have to bear our job in America if we are going to get it done.

Value of Public Hearings

Commissioner RUSSEL V. LEE. I would like to supplement what Mr. Reuther has said in justice to the rest of the Commission. It of course would be perfectly absurd to base our conclusions on the evidence that we receive in these public hearings—these 10-minute sessions—even though such evidence is supplemented by a considerable amount of written material, and sometimes a very considerable amount.

I will say that out of these public hearings has come things of extraordinary value to me personally. I have done a lot of study on this subject and to my surprise I have found things in every one of these public hearings that are valuable to me.

But beyond that, we have been working a year, and have had an extraordinarily good staff; four of the best people in the health field I have ever worked with have been on the staff, with a large number of others. I think we have gotten together by all means the largest and most important collection of material on the socioeconomic side of medicine that has ever been gathered—material here and abroad. If we reach no recommendations, the bibliography and the documentation of that material will be worth all it has cost this Commission.

In addition to that we have had a lot of original studies, we have had the 400 witnesses Mr. Reuther talked about. I think practically every authority

in every field of medicine has been invited, and most of them have come. That testimony will also be available for anybody in the future who wants to work in this field.

It has not been any superficial job as far as I and most of the other Commissioners are concerned. We spend most of our spare time every night reading material, and then writing for the Commission. That has gone on for 10 months. This hearing today is just one evidence of the interest that we have taken in our work.

As you see, people will come and will spend all day, they will stay until 6 o'clock, and 7, at night in these hearings. People are really interested in health care, and we are interested in getting cooperation of all segments. And we have had fine cooperation from the medical people in each of these public hearings, with perhaps one exception.

Dr. STONE. That of course is evidenced by these meetings and this meeting today particularly. When I came here last night and talked to the men from Michigan and the men from Indiana, I realized that there was an earnestness behind it all, when I left Chicago after I had talked to my executive council there of the State—I am chairman of the Council of the Illinois State Medical Society—when I talked to them they were very skeptical.

They said they wanted to send a letter saying they might send a more complete report at a later date. But after talking to Mr. Wagner of Indiana, and some of the other men, I felt we should at least present something, with the idea of making it known that we want to be included in this entire set-up.

Commissioner LEE. We would like to have it and we will give it sober consideration when it comes in.

Statement¹ of

DR. H. M. CLODFELTER

President,

The Ohio State Medical Association

Columbus, Ohio

Permit me to thank the Commission for this opportunity to present some information which may be of help to the Commission in its deliberations.

In our opinion, the medical and health situation in Ohio should not be viewed with alarm; neither should it be viewed with complacency.

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

The medical profession of Ohio recognizes that we have some health problems in this State. We know there are some weaknesses in the programs being undertaken to make good medical and health services available to the people of Ohio.

The Ohio State Medical Association pointed out these facts in May 1946 when its House of Delegates adopted a "Health Program for Ohio," which enumerated needs and made recommendations to meet them.

Our program, which we are actively supporting, if converted into total achievement, would insure adequate health and medical services for the needs of Ohio citizens.

We stated then, and repeat now, that we believe the needs and deficiencies existing in Ohio can be met by Ohio. The resources are available and the will to do the job is becoming increasingly apparent.

I think I can report substantial progress. At the same time, goals have not been reached in all instances.

The Record

Let's take a look at the record:

1. Ohio has an efficiently operated State Department of Health which compares favorably with those of other States.

However, it is constantly plagued with financial and personnel problems.

It is not receiving adequate financial support from the State of Ohio. It has been forced to rely too heavily on Federal grants for department operations.

Because of this, it has been unable to engage in long-range planning. Through necessity, it has had to withhold some Federal grants from local public health departments to meet the costs of central office activities.

The General Assembly in 1951 did vote a small increase in the biennial appropriation to the Department—a step in the right direction—but new legislative enactments which placed additional obligations on the Department canceled out this gain.

The people of Ohio are beginning to realize that the State of Ohio can and should provide adequate financial support to this important department. Therefore, I am confident that we can anticipate real improvement in this situation.

Our Health Department, like most of the other departments of the State government, has difficulty in securing and retaining well-trained professional and technical personnel. One of the

primary reasons for this is: Low salaries and wages paid by the State.

One of the things which must be done is for the State to increase its salary and wage schedules to a point where it can really compete for the services of professional and skilled personnel.

The next General Assembly will take some corrective action, I believe.

Local Public Health

Ohio has some excellent local public health departments. On the other hand, Ohio has too many poorly financed, poorly manned and poorly operated local health departments. These departments are endeavoring to serve population areas too small to provide adequate financial support.

Consolidation of many of our local health departments is necessary. Until this is done, some areas will not have adequate public health protection.

A law to permit counties to make special levies for local public health units was passed in 1951.

Undoubtedly, new attempts will be made during the next legislative session to strengthen our local public health agencies. These may be in the form of legislation to reduce the number of departments or additional measures to improve ways of financing them.

Number of Physicians

Statistically speaking, it would appear as if there are a sufficient number of physicians in Ohio to meet Ohio's needs.

But, the situation is not quite that simple.

There are communities in Ohio which need the services of a physician—one who resides within the community or in a nearby town.

Some of our cities which have increased in size rapidly during the past few years could use additional physicians.

Some of our official agencies and institutions are in need of medical personnel.

The situation generally is not critical. Nevertheless, those in touch with existing conditions agree that Ohio could use to good advantage an additional number of well-trained physicians.

At the same time, we must continue our efforts to bring about a better distribution of our present medical manpower, as maldistribution is one of our major problems.

Facilitating Physician Services

The Ohio State Medical Association has taken the lead in trying to make good medical care

readily available to all the people in every community of Ohio.

Its Physicians' Placement Service has assisted many areas in securing a physician.

Through the Association's efforts, more than half of the county medical societies in Ohio have set up emergency call services, which make it possible for anyone to secure the services of a physician at any time—day or night, Sunday or holiday.

The Association makes a substantial financial contribution to and cooperates with the Ohio Military Advisory Committee. The function of that committee is to try to maintain a balance between the demands of the Armed Forces for physicians and the needs of local communities. The Korean War has aggravated the situation. Many young doctors who normally would be entering private practice and many who have just started practice are being called to military service. Finding replacements for these physicians is one of the major activities of the Association.

The Association has given its active support to the expansion program at the Ohio State University College of Medicine. It is now admitting 150 freshman medical students—a 100 percent increase over 1949 and previous years. It is supporting efforts of the medical schools at Western Reserve University and University of Cincinnati to expand their facilities so more students can be admitted and graduated.

At present the Association is carrying on a fund-raising campaign among its members in support of the American Medical Education Foundation, which provides financial assistance to all medical schools. Ohio's three schools to date have received a total of \$110,000 from the Foundation. Increasingly larger grants will be made, we are confident, as the Foundation's resources increase.

We have sponsored activities to increase the number of general practitioners. We have urged medical schools to place greater emphasis on the training of physicians for general practice. We have presented a series of lectures on general practice to the senior medical students at Ohio State University, and we are planning to do the same at Western Reserve and Cincinnati.

We are providing annually four medical school scholarships at \$500 each. Known as the Ohio State Medical Association Rural Medical Scholarship, it is presented each year to an Ohio boy or

girl from a small or rural area who has expressed a desire and willingness to enter a small area for general practice upon completion of training.

Community Health Councils

Active support has been given to the formation of Community Health Councils. We believe they can play an important part in bringing about economic, social and environmental improvements in their areas—factors which are important in securing and maintaining the services of a physician, medical facilities and health services.

We have actively supported Ohio's largest hospital building program. The opening of hospitals in many smaller communities has influenced young physicians to move into those localities.

Nurses

One serious problem confronting Ohio is the shortage of nurses. The reasons for this are well known, among them being the so-called "marriage mortality" among nurses and the better opportunities for financial reward offered by other vocations to the girl planning a career.

Official recognition of this problem was given by Governor Lausche several months ago. He called a State-wide conference. Later, he named a committee, which is studying the matter and will make recommendations for meeting it.

Many organizations, including the Woman's Auxiliary to the Ohio State Medical Association, are sponsoring recruiting drives for the nurse training schools, are offering scholarships, and are creating loan funds. Hospitals conducting nurse training schools are offering special inducements to secure students. The State Nurses' Association has a committee giving special attention to this problem.

Budgeting Against Costs

Ohio has done an excellent job in providing ways for wage earners to budget against the costs of medical and hospital care for themselves and their dependents.

Its Blue Shield Plan—Ohio Medical Indemnity, which was organized by the Ohio State Medical Association—is now providing surgical and medical coverage for approximately 1,310,000 Ohioans.

Its Blue Cross Plans are providing hospital coverage for approximately 3,500,000 Ohio citizens.

Many other Ohio citizens are covered for medical and hospital benefits through programs under-

written by commercial insurance companies or through employee benefit plans.

The Blue Shield and Blue Cross Plans in Ohio have made a consistent effort year after year to give their subscribers better coverage and additional coverage without increases in premiums. Occasionally, small premium increases have been necessary to meet increased costs due to inflation.

These voluntary insurance plans are providing a sound and substantial cushion for the average working man and his family. We are working to improve them. Coverage will be expanded when this can be done without undue financial risk.

We need and are working for a better program for the care of the handicapped and indigent—primarily the responsibility of the State and local subdivisions.

Hospital Building Program

I have already mentioned Ohio's hospital building program. It should be continued as we need additional hospital beds. At the same time, the danger of overbuilding should not be ignored. The people of every community should realize that it is their responsibility to provide adequate financial support for their hospital.

Some parts of Ohio should have "health centers" with facilities for the handling of emergencies and for diagnostic procedures which would be available to all practicing physicians of the area.

Our programs for the care of tuberculosis patients are not perfect, but we have made substantial progress in recent years. A new 300-bed tuberculosis hospital has been opened at the Ohio State University Medical-Health Center. The State is now providing an annual subsidy amounting to \$3 million to the counties for the hospitalization of tuberculosis patients.

Several new chronic disease hospitals have been built. Others will have to be built later, as institutionalized care for those with chronic and degenerative diseases is a growing necessity.

Ohio's record in caring for the mentally ill has been spotty. In recent years, however, there have been notable improvements. Many new facilities have been built from the surplus funds of the State. Seven receiving hospitals where short-term cases can be cared for have been erected and two others are under construction. An improved mental health educational program is under way. A number of local guidance centers have been opened and others are being planned. It is under-

stood that the next Legislature will be asked to appropriate an additional \$25 million for further expansions of our mental health program.

I shall not have time to mention many other subjects of interest and importance.

These are covered in a detailed statement which I would like to present on behalf of the Association at this time for the Commission's consideration.

In conclusion, may I again point out that we are aware of our needs and deficiencies and that we are endeavoring, with the help of many other groups, organizations and agencies, to do something about them. We have made progress, and we are confident of greater progress during the next and succeeding years.

Statement¹ of

DR. CHARLES HUDSON

President

**Cleveland Academy of Medicine
Cleveland, Ohio**

The Medical Profession of Cleveland, 95 percent of which is represented by the Academy of Medicine, thanks the President's Commission on the Health Needs of the Nation for the invitation to appear before it. As spokesman for the Academy of Medicine, I should like to present the physician's views on certain matters pertaining to the health of this community.

These are fields in which we believe that doctors speak with some authority:

Doctors

1. Supply of Personnel—Doctors.

We are not using the Commission's language which is "shortage of personnel" because it is our belief that in general the ratio of physicians to population is adequate. The Cleveland area with a population of approximately 1,250,000 has some 2,800 physicians. Of this number about 1,800 are in private practice, the balance being interns and residents, full-time teachers and administrators, public health physicians, and so forth.

This means that there are about 650 persons to each physician in private practice. During the war, the Armed Services felt 700 persons per physician was an optimal ratio and 1,100 per physician would not create too great a burden. As a

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

matter of fact, by reason of enlistments the physician population of 2,500 was reduced by 600 or 700 during the entire 4 years without serious trouble.

Our membership records show that the number of physicians in private practice increases each year by about 2 percent, which is comparable to the population growth, or a bit beyond it.

The geographic distribution of physicians seems reasonably adequate to the community needs, and most physicians' offices are within a few minutes' drive of residential sections.

Within the profession itself, the distribution is well balanced in most types of practice. Some of the specialties, however, are probably undermanned—notably pathology, psychiatry, and ophthalmology. The sudden popular acceptance of psychiatry found us with too few psychiatrists. The practical solution is not only to produce more psychiatrist-specialists but to have all doctors with some appreciation of and competence in the field. The long waiting lists in ophthalmologists' offices reflect the demand for refractions by doctors. This results in inconvenience rather than harm, as the ophthalmologists in my experience have always been able to see patients in an emergency.

I realize that this evaluation of the supply of doctors is only one method of approach, and I am not satisfied that it tells the story completely. Our committees are currently studying medical care in relation to public welfare activities, largely for the accumulation of information and promotion of understanding rather than because of any implied criticism of existing agencies. We cannot predict what the outcome will be.

We feel that in thus considering the supply of doctors we should not be accused of complacency nor of attempting to restrict the number of doctors. It is just that the situation in this regard is not one of emergency and need not force our medical schools to lower the quality of medical education in order to produce doctors in quantity.

The supply of personnel auxiliary to medicine will be discussed by others.

Meeting Existing Needs

2. Our second selected subject is "the degree to which hospitals and clinics meet existing needs."

The growth of hospital insurance plans has created a demand for beds, partly for previously neglected medical and surgical conditions but also for the satisfaction of desires which are largely unpredictable. Demand for beds is heavy on Sun-

day night—because that permits the longest possible week of laboratory study—and conversely, we can usually get a patient admitted during Christmas week. One cannot always have any patient admitted on demand, but emergencies are taken care of.

Beds provided for long-time illness and judicious reduction of number of cases admitted for study should free up the general hospitals satisfactorily. This quick summary is not entirely satisfactory but neither is a quick decision to order more beds. As a matter of fact, the number of available beds has been steadily increasing. The story of the fine work of the hospitals will be amplified by others.

As for clinic or out-patient services, some figures from University Hospitals are interesting: In 1941, the waning of the depression, there were 148,000 patient visits.

With increase in employment during the war, the number decreased in 1945 to 73,000. These figures show:

- (1) That the supply of clinic services is flexible and probably adequate;
- (2) That when they are able, people prefer to go to a doctor's private office; and
- (3) That the demand for clinic services varies with economic conditions through a very wide range.

3. In regard to our third subject, medical care insurance plans, we favor and support voluntary plans which are increasing in force. The Academy has recently furnished the impetus for a payment-in-full-type insurance plan for doctors' services which is being offered by local and national companies. We are confident that these plans will develop sufficiently to care for the insurance needs of the people. We believe that the fact that they do not cover everybody, for everything, is a virtue rather than a defect.

Other Factors Materially Aid

There are factors which do not appear in the tabulation of health resources but which are nevertheless important in that they enhance the effectiveness of the resources available.

I refer to the new medicines and new surgical techniques which make the doctor more effective than in the past. By-products of this effectiveness are reduction in total days of illness and shortened hospital stays.

Improvements in communication, in automobiles and in roadways also contribute helpfully.

A more judicious use of medical services could add to their total effectiveness and help still more. The Academy of Medicine, with its full-time staff office, its educational programs for both doctor and the public, its telephone call service, its good relations with the public and with the press and its past and present interest in the health matters of the community, contributes as an organization to the total value of medical services.

Conclusion

In conclusion may I express the hope that the real fruit of these health hearings, here and elsewhere, will be the stimulation of citizens locally to continue to study and work with their health problems. I do not minimize the importance of the committee's final report, but I have a conviction that changes in the provision of medical care, where indicated, will for practical purposes be accomplished by local people. Social problems are not easily solved by calculation from a remote position.

The facts obtained by comparing health needs and resources relate to human wishes and desires, and, being highly variable, they cannot accurately be integrated with more nearly measurable categories. These "facts," so-called, also are subject to interpretation and instead of leading to agreement by reasoning, lead more often to argument.

Social problems, I believe, are solved by continuous action and interchange of ideas of people in the field. From this point of view, the health resources of Cleveland are the many skilled workers in our numerous health agencies, a well developed civic social conscience and a willingness to cooperate in our work.

Commissioner ELIZABETH S. MAGEE. Dr. Hudson, on the question of the number of physicians in the population, do you know how this ratio compares in the Cleveland area with the United States as a whole? That is naturally one of the things that we are asked to look into.

Dr. HUDSON. It really is a problem of locality. There are places where doctors like to settle where the figures are much higher than this and there are places where the figure varies in the opposite direction, but I should say that although I am not positive of this number it is better than average.

Hospitalization Period

Commissioner RUSSEL V. LEE. Yes, that is true. You are one of the best if you have 1 per 650.

Do you think patients in general in the last few years are being overhospitalized?

We have the impression concerning many places that with the growth of insurance programs many people who could be cared for at home go to hospitals, and are kept in hospitals longer than they need be. Perhaps, then, some of the hospital bed need is not entirely realistic.

Dr. HUDSON. I implied that in my statement. I think that the total number of days' stay is not excessive. I think it is a matter of record that the number of patients cared for in the hospitals has increased and the number of days per stay has decreased with the various techniques that we now have.

The matter as to whether or not people are admitted unnecessarily always gets an argument. I have a feeling that in hospitals where I am well acquainted that there are a number of people who go to the hospital to receive study who could just as well receive it as ambulant patients.

Commissioner LEE. So many of the people are eligible for payment under these insurance programs only if they go to hospitals.

Dr. HUDSON. Yes. I think it would be a good thing if it were practicable. The insurance people like to have some sort of safeguard. You cannot predict adequately and accurately how many times somebody will just like to get his stomach X-rayed, or something like that, and insurance statistics and predictions of call upon services are therefore unreliable, or rather unreliable.

We have a safeguard, a restriction in the number of beds available. That keeps down the demands for this type of service.

I think if the patient paid for part of the study and if the doctors cooperated by ordering just the things which they considered were needed without undue influence by the personal requests of the patient, that some sort of plan like this could be put into effect.

Hospital Staff Appointments

Commissioner RUSSEL V. LEE. Dr. Hudson, we found in New York that only 50 percent of the doctors there had any access to a hospital and only 35 percent in Baltimore. Do you know anything about the similar situation here? I mean they have no hospital staff appointments and no possibility on their own of getting patients into hospitals. Do they have a closed-staff system here pretty generally?

Dr. HUDSON. It is restricted. I think each hospital feels if it is an individual concern that it not only has the right but there is an obligation to select the physicians that practice in it and on that account I am sure that selection does take place as to the personnel of the staffs.

I think, to a large extent, that is entirely justifiable.

As to any great number of physicians being unable to take their patients to the hospital, I think there is no such great number or I would have heard more about it.

I think there are individual instances that one could find any time.

Statement¹ of

DR. C. E. UMPHREY

Immediate Past President

Michigan State Medical Society

Representing Michigan State Medical Society

Make no mistake about this: The people of Michigan are healthy, and Michigan doctors of medicine are vitally interested in making our people healthier. It is equally true that:

1. The cost of medical care is reasonable, but Michigan doctors of medicine are working vigorously toward lowering the financial strain of catastrophic illness, which is the real need of the people.

2. The supply of doctors meets the basic requirements of our people, but Michigan doctors of medicine are actively engaged in obtaining more doctors of medicine and more medical associates in order to reach the optimum in doctor distribution and supply of medical service. Perfection in this is probably impossible on this earth, but there is a continuing need to try to attain perfection.

3. The continuing educational program within the medical profession is the most intensive and extensive of any professional or business group in the world. But the Michigan doctors of medicine are constantly expanding and extending their postgraduate education programs. They recognize the constant need of learning the newest advances.

4. The health facilities of Michigan—that includes hospitals and hospital equipment, clinics, medicines and all the appurtenances of modern medicine—are today at an all-time high. But

Michigan doctors of medicine are fighting for more and better facilities in order that the need for maximum service can be met.

Health Information

5. Our people are more interested and knowledgeable in health matters than ever before—but Michigan doctors of medicine recognize that one of the primary responsibilities for the health of the people lies with the people themselves. However, doctors are dissatisfied with the extent of good health practices and feel that people need a great deal more health information. Consequently, these doctors of medicine are spending their own money and freely sacrificing a tremendous amount of time to hammer home the facts of health to every individual in Michigan.

Regrettably, lay organizations—and we refer to some labor unions as the most grievous offenders—have not provided their members with authentic health information which is freely available from the Michigan State Medical Society. Unions have ignored the opportunity of educational services of doctors of medicine and specialized health organizations for their members. There is a real need for a greater health educational effort by lay organizations to their members.

6. Our people are at the highest peak of health in the history of this State, but Michigan doctors of medicine, who accept some of the responsibility for that situation point to the social needs which have arisen as a result of increased health. They point in particular to an increase of older age groups—and they are seeking to do their part in providing an answer to this problem.

Needs Related to Cost of Medical Care

At the risk of oversimplification necessitated by the ten minute limitation on time, we quote statistics from the U. S. Labor Department reporting that living costs in general are rising faster than the cost of medical care. Compared with a 69 percent boost in living costs during the last 10 years, hospital bills went up 67 percent, doctors' bills rose only 38 percent and prescriptions but 37 percent. The question is asked: Who is responsible for the 69 percent boost in living costs and who is responsible for the comparatively small increase of 38 percent in doctors' bills?

One more comment of this problem. Protection against the health service. The Michigan State Medical Society has pioneered in building such protection. It is primarily responsible for

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

Michigan Medical Service (Blue Shield) and was a stimulus in the original organization and development of Michigan Hospital Service (Blue Cross). The MSMS has repeatedly been of service in assisting these two organizations to reach and maintain their present enviable position as leaders among the voluntary non-profit prepaid medical and hospital service plans. At the same time, sincere encouragement has been given to all other reputable voluntary health insurance plans as protectors against the cost of medical catastrophes.

Needs Respecting the Supply and Distribution of Doctors of Medicine

Michigan has a population of 6,371,766. There are 6,937 doctors of medicine in Michigan. This provides a ratio of 919 persons to each doctor of medicine.

It is repeatedly stated in industrial, health service and insurance planning that a ratio of 1,200 persons to 1 doctor of medicine is required to meet the health needs of the population.

In spite of the fact that Michigan has enough doctors of medicine to meet basic requirements, our two medical schools, Wayne University College of Medicine and the University of Michigan Medical School, have increased their capacity, so that in 1953 the Detroit school will be able to accept 100 new medical students each year, and from 1957 on will graduate 95 doctors of medicine each year.

And at Ann Arbor the largest medical school in the world today accepts 200 medical students every year, and beginning in 1955 will graduate 190 doctors of medicine annually. Under the present arrangements a total of at least 8,948 doctors of medicine will be serving Michigan by 1960. There may be more than this because, through the farsighted cooperation of the 1952 legislature, a revision of the Medical Practice Act and the Basic Science Law last May has resulted in an influx of doctors of medicine into Michigan from other states, totalling 63 (out of a total of 166) in the past four months, and they are still coming. A surprising number are establishing practice in rural areas.²

² In addition to all this, the "productivity" of doctors of medicine is being augmented by:

- (a) Increasing facilities for treating patients (there will be other reports on this, no doubt).
- (b) Increasing knowledge and skills in treatment.
- (c) Increasing speed of patient contact.
- (d) Increasing number and use of medical associates.

Distribution of Doctors

The distribution of medical care and medical services is a full-time project of the Michigan State Medical Society because it is a continuing need.

The Doctor-Placement program of the Michigan State Medical Society is one vehicle used in solving the problem of proper distribution of doctors. Lists of doctorless communities are sent out each month to doctors looking for locations, while similar lists of available doctors are sent to any areas requesting information on the availability of physicians.

It has been stated by expert statisticians and sociologists—remember they are not doctors of medicine—that we will have an oversupply of doctors of medicine within 10 years.

The real need of the present lies in the scarcity of medical associates. A vigorous campaign for more medical associates was inaugurated several years ago by the Michigan State Medical Society. We place in evidence the brochure called "In Planning Your Career, Consider the Possibilities of a Medical Associate," which is in its second printing and is still the best piece of literature to introduce this wide-open occupational field to prospective students. We seek the constructive help of all lay organizations to this end.

Need for Continuing Medical Education

The members of the Michigan State Medical Society recognize the need for being constantly aware of the newest advancements and discoveries in their profession. They are doing so through a continuing postgraduate education program.

Foremost project is the extramural teaching program which brings eminent clinicians and teachers from the State's two medical schools to approximately 25 Michigan areas during the course of a year. These top-notch programs bring to the busy doctor the opportunity to learn the newest procedures, etc., without having to leave his particular locality.

Additional opportunities are given too for postgraduate education in the MSMS annual session every September and the Michigan Clinical Institute every March. In fact, the September annual scientific meeting of the Michigan State Medical Society begins tomorrow, September 24 and will continue through Friday, September 26 here in Detroit. An average of 3,000 M. D.'s crowd the annual session and nearly 2,000 attend

the clinical institute. Both are 3-day concentrated sessions. These sessions, of course, are in addition to the thousands of meetings on scientific subjects of county medical societies, specialty groups and hospital staffs.

Need for Health Facilities

The increase in health facilities has been phenomenal since World War II. Undoubtedly others who speak will cover this subject.

The tremendous increase in privately owned health centers and well equipped medical and surgical offices which dot the neighborhoods of every city and town in Michigan must be noted as tangible evidence.

Need for Education of the Public

A great share of the energies of Michigan doctors of medicine is devoted to a program of public education designed to keep our people informed of all the latest changes within the health picture.

The public education program is developed and led by a large Committee on Public Education. This Committee is in turn broken down into various subcommittees for the purpose of preparing and disseminating information through the various media. The Michigan State Medical Society makes liberal use of every media to tell the story of good medicine. Our Michigan doctors of medicine have underwritten the cost of this vast information program, and the people have gained much during this 7-year campaign.

We have worked in close cooperation with every legitimate specialized health association; particularly in disease control programs such as the rheumatic fever control program. We have given our services freely for purposes of education to any and all groups requesting aid. The only major group that has not repeatedly requested educational assistance from the organized medical profession of Michigan has been the labor unions. And we are ever ready, willing and able to help. There is a real need for better education of the public on health matters.³

³ According to recently released statistics (September 1952 "Mutual Minutes"), there have been 9,193,000 casualties in 1952 in the United States. Each day there are 255 deaths; 25,000 casualties; 35,000 people are hospitalized each day; 5,000,000 require surgical operations during the year; 4 out of 5 persons are sick during the year and 1 out of 9 of the sick will go to the hospital. Of these, four will need some sort of financial help which will be adequately served by the splendid medical and hospital service and insurance companies of America. These things will happen. But greater effort spent on reducing casualties by lay organizations can be a major factor in lowering the incidence.

General Health

As Michigan's population increased from 2,420,982 in 1900 to 6,371,766 in 1950, the birth rate increased more than 25 percent; the death rate dropped 36 percent; the infant death rate declined 84 percent and the maternal death rate all but disappeared. Preventive medicine, antibiotics, miracle drugs, new surgical and diagnostic techniques, more and better trained doctors of medicine and bigger and better hospitals have almost conquered disease, so that the major killers now are automobile accidents and illnesses that hit older age groups through weakened hearts and hardened arteries. This is the field of geriatrics—a field too great for us to cover in the ten minutes allocated—but upon which other representatives of medicine are prepared to report.

The really great needs in medicine today have been recounted. In the same degree as they are met, other special health problems will arise and be moved toward solution. Meeting these needs brings new horizons of need, because "horizons of need is synonymous with "possibilities for progress."

Conclusion

Health and medical services were never so good. Although there are certain persons who like to shadow box with health bogeymen, we must continue to recognize and meet the basic needs calmly, analytically and fearlessly. We should not be led astray by isolated dramatic instances which are sometimes cited in order to replace reason with emotionalism. Certainly the record of accomplishment in health by voluntary methods has obviated the need for further depletion of an already overloaded federal budget by the introduction of more extensive inroads into Michigan Health by the Federal government.

Hospital Staff Appointments

Chairman KENNETH B. BABCOCK. Are there any questions of Dr. Umphrey?

Commissioner RUSSELL V. LEE. Dr. Umphrey, I would like to ask you a couple of questions.

What about hospital facilities for your doctors?

Have all your doctors access to hospital staff appointments?

Dr. UMPHREY. The staff appointments are all available. That is up to the credential groups in each hospital. Each hospital is an entity unto itself. These doctors of course—if they join the staff and have certain personal privileges—must

have proved their right to practice that particular specialty, whatever it is.

Commissioner LEE. What I would like to get at is: About what proportion of the doctors, let us say of Detroit, have staff appointments in hospitals and what proportion does not?

Dr. UMPHREY. Dr. Babcock, can you answer it?

Dr. BABCOCK. I cannot.

Dr. UMPHREY. Here is a hospital superintendent that can't answer it. I do not think I can.

Commissioner LEE. It is a sore point in a good many cities we have been in. A lot of doctors complain they cannot get on a hospital staff and cannot practice proper medicine unless they do. I wonder what that situation is here.

Dr. UMPHREY. I will only say this. I think there is some merit to that criticism, too. But I think that we have in our hospital program—and Mr. Reuther could answer your question as well as I—in this program of hospital beds, we have here a program I think which is going to bring us to a position where every doctor that is ethical and has the training will be in a position to have available the facilities of hospital beds and everything that goes with them.

Commissioner LEE. You do not have your beds per population in this state?

Dr. UMPHREY. I think you will have that.

Health Insurance Contract

Commissioner LEE. One other question about your medical service plan.

The Michigan Society, as I remember it, sponsored about the first of the State society insurance plans, did it not?

Dr. UMPHREY. I think it was second. It was one of the first.

Commissioner LEE. You came about the same time California did.

Dr. UMPHREY. Yes.

Commissioner LEE. Are you giving a service contract now or an indemnity contract for medical service?

Dr. UMPHREY. How would you classify that?

Dr. BABCOCK. Service for those below certain set incomes and above that indemnity is supplemental.

Commissioner LEE. That is all.

Dr. BABCOCK. Could I ask you one question?

Whose figure is it that states 1 doctor per 1,200 population is all that is necessary? I have heard 1 to 700 and 1 to 900.

Dr. UMPHREY. I can't say now. I can get those figures for you. For the Commission I will be glad to get them and the reference.

Commissioner WALTER P. REUTHER. I think the record will indicate clearly that the labor groups are becoming more and more conscious of the need for a lot more attention on the health needs of workers and that sort of thing. I think in the State of Michigan, if you will check the history of how Blue Cross was developed, you will find the labor unions were in that effort very early.

Dr. UMPHREY. Yes, they were.

Commissioner REUTHER. At a time when many of these doctors were not prepared to go along with the whole concept of Blue Cross. I would like to ask this.

I think labor, while we have made great progress in this field, has still a great deal to do before it makes its full contribution both to its membership and to the communities. I would like to ask specifically what kind of service the medical profession offers that you say labor is not taking advantage of now? I would like to take advantage of these services.

Dr. UMPHREY. I talked to you some time ago and I came to you with this appeal: "Mr. Reuther, if you have any problems, or if we have something that we can give you in the way of information, I would like to do it." That was the last that was heard of that.

"We would like a little closer association with your organizations and we would like to work a little closer with you and bring what we have. We are a big organization; we have a lot of information on health; and we would like to make it available to you so that you can make it available to your membership."

That is just what I said.

Commissioner REUTHER. Do you have printed material?

Dr. UMPHREY. Yes, we have printed material and we have speakers—a speakers' bureau—and we would be glad to bring that information to you, sincerely glad.

Dr. SCHULER. My name is Schuler, connected with Wayne University. If I understood correctly, Dr. Umphrey said it has been stated by experts, statisticians and sociologists and so on, that we will have an oversupply of doctors within 10 years. Is that correct?

Dr. UMPHREY. Yes.

Dr. SCHULER. I would just like to know for the record who the experts are?

Dr. UMPHREY. You have here in your program the name of our secretary and let us send you the material, will you?

Dr. SCHULER. Yes.

Dr. UMPHREY. Fine.

Dr. WHITTAKER. I am Wayne Whittaker. I would like to mention that the University of Michigan has the largest entering medical classes in the United States. I do not think that we want to be the largest medical school in the world.

Dr. BABCOCK. The new AMA Journal showed them to be fourth. I just looked it up.

Dr. UMPHREY. Your modesty is refreshing.

Statement¹ of

DR. WARREN F. BERNSTORF

President

Kansas State Medical Society

Topeka, Kans.

It is with pleasure that your invitation to appear before this Commission is accepted, because the problem of providing adequate health care to all people in our State has occupied a large portion of our attention during the last 6 years. It is our belief that we can now demonstrate considerable success from our program, which I beg to outline as one method for dealing with the questions you are charged to answer.

I am confident at the outset that my viewpoint, colored by the private practice of medicine, will differ from the views some of you will have, particularly with reference to the specific subjects you have elected to explore. I am, for example, more familiar with the practical side of medical care and, therefore, do not consider myself qualified to judge the adequacy of medical research. Looking at this from the record of achievement, of advancements during the past few years, research appears to have been effective.

On public health, also, we probably will not agree because in our State there are relatively few full time health departments or physicians who specialize in that field. A statistical report would make our situation appear inadequate, but statistics are not more significant than results. Regard-

ing the latter, we will not apologize for our services before any state. Where public health care is lacking, the local profession performs these duties and doctors have served their communities well. Ours, we believe, presents a most favorable morbidity and mortality record. We know our maternal mortality to be among the lowest, and rejections by selective service for physical reasons in Kansas have stood at the smallest figure in the Nation.

Therefore, answers to the questions you ask cannot be definitive or direct. They must be relative and will quite naturally be colored by the approach or inquiry. No one can claim that medical care is or is not out of reach of the average citizen. Numerous studies in economics have tracked this subject down more than one blind alley, so any further exploration is not practical within the 10 minutes allotted to me.

What Kansas Is Doing

I would rather tell you what Kansas is doing and how our people are trying to meet both the problem of shortages and of expense. I only regret that I am unable to expand this outline to bring you details of our story. However, it goes something like this:

Like most other places, Kansas suddenly found herself short of medical care and blamed the war. We made a brief survey in 1946 and learned some startling facts.

1. Ever since 1900, Kansas has had fewer doctors each year than the year before.

2. Between 1900 and 1942 (before the war had any effect on this problem) we had gained 25 percent in population but lost 30 percent in our physician number. It is true that improved travel methods, and other factors, reduced the number of doctors needed but our shortage was acute.

3. During this same 42-year period, a continuing and unnoticed migration had been occurring. The physician moved from rural areas to the city. In 1900, 57 percent of all doctors practiced in towns of 1,500 or less. By 1942, this had reduced to 28 percent.

4. And, finally, we learned that this bad situation would rapidly grow worse. In 1946, the average age of Kansas doctors practicing in cities was much lower than those in rural areas. Forty-three percent of the physicians in cities had

¹ Delivered at the Regional Hearing at St. Louis, Mo., September 15, 1952.

reached the age of 50, but in towns of 1,500 or less, 77 percent were that old or older.

The "Kansas Plan"

We played with many ideas on how this could be corrected and finally arrived at what has now become known as the "Kansas Plan." The formula is simple. We lay no claim to originality, but it works, and within this framework, we have gone a long way toward solving our problem. If we can be permitted to continue our effort, we will prove the effectiveness of the program and will achieve this without artificial inducements or controls, without subsidies or bribes, and practically without Federal assistance.

We have the people of Kansas to thank for its success. They, and especially the farmer, for whom rural shortages were most significant, put the program into effect. We helped through giving advice and by cooperating in every way we could—but the farmer made it work. I stress that point here and shall do so once more at the conclusion because it is the focal point of the venture.

I am completely convinced that artificial stimulus, subsidies or appropriations in any amount whatsoever, without the active participation of the people themselves, would doom this or any similar program to failure. I also know that the converse is true—when local interest is sincere, artificial stimulus is unnecessary. The American people are resourceful. If they want something badly enough and are shown a logical plan for obtaining what they want, they will do the rest. We can demonstrate this fact.

Three Basic Points of the Plan

But first, a very brief review of the three points that make up the "Kansas Plan."

The first is to increase facilities for medical education. We realized early that if Kansas would ever have adequate medical care, we would need to train more Kansas young men and women in medicine. The 1949 Kansas Legislature, at the request of farm people, appropriated almost \$4 million to enlarge the School of Medicine at the University of Kansas. The former maximum enrollment in any class was 80. In 1953, the freshman class will accept 120, an increase of 50 percent, many of whom will be young men and women from rural Kansas, persons most likely to select rural communities in which to practice.

Point two deals with medical isolation, the fear of which probably became as important a factor in the creation of rural shortages as anything else. We are correcting this through two principal programs, first by bringing graduate education directly to the doctor and, second, by having a second physician move into the community. More and more Kansas communities are receiving their second doctor and even when these are not directly associated, they have consultation available and can obtain periods of rest.

The third point is preparing the community to receive a doctor. Here is where the people act to solve their own problem. We try to advise them as to what a physician wants when he explores a location. There are many phases to this discussion but the following will illustrate our approach:

Approach Employed

1. The doctor wants reasonable assurance of economic security. This can, of course, quickly be determined and in many Kansas communities. The demand is sufficiently great that the answer is instantly apparent.

2. He wants a place where he may work—a hospital, because modern medicine needs the services of the laboratory, the X-ray, and nursing care.

3. The young physician is frequently without funds and heavily indebted. He needs help. We have learned through brief but unpleasant experience that gifts are wrong. Obligating his future makes him dislike his location, and the people are equally unhappy with him under those circumstances, so we heartily recommend against any bonuses or financial inducements except credit. He needs help but is as certainly an independent businessman as anyone else in the community and prefers to make his own way. Therefore, he may need a loan, and this can be arranged easily.

4. Perhaps the most important single factor of all is that he selects a community as a place in which to live and rear his family. This, apart from economic considerations, involves social, educational and religious facilities. It concerns the doctor's wife and whether she will be content.

Perhaps the broadest general statement is to say that the town must have a sense of civic pride. The success of rural Kansas in this effort has been phenomenal. The small town has come to life. It is modern in its facilities and modern in its

outlook. With only a few exceptions, the doctor who selects a small community in which to practice plans never to leave it. He soon becomes a part of the town. He finds an interest in local school functions, in the Chamber of Commerce, in his county fair. He shares with the banker, the merchant and the preacher, the hazards of this small community. Together they mean to win—and they will.

How It Has Worked

Now a word on how this has worked. The people of Kansas have become health conscious and have made sacrifices to obtain the services they want. By way of example, we have built, or are now building in Kansas, 78 separate hospital projects since the close of the war. As each is completed, one, and often more than one, doctor moves into the community. These now dot the entire State and there are today very few persons who live more than 25 miles from a hospital.

We believe it to be of interest to note that 60 percent of these hospitals were built without Hill-Burton money. Our communities elected to finance their own projects, either by voluntary contributions or local taxation, rather than to accept federal aid. The great bulk, much more than 60 percent of the total Kansas allotment from the Hill-Burton program, went to our state-operated health institutions such as our medical school.

We can support our claim of success with these figures. Our attrition rate is about 50 doctors a year. During each of the last 2 years 150 have located in Kansas and many, 67 of these, have selected towns of 1,500 persons or less in which to practice.

With only negligible exceptions, the doctor intends to make this his home. He not only practices medicine here, but enters into community affairs. So the total effect reaches beyond the subject of health care to include all phases of living. The people of our State are planning toward the future. They have suddenly found a new confidence. They are building new schools and churches and recreational centers. They are paving the streets of these little towns, putting up lights and not only are they getting better medical care, but all other things that increase their standard of living.

This, then, is the story of the "Kansas Plan," an experiment in what people can do for themselves if given the opportunity. We believe our program will succeed and that Kansas can take care of its problems.

Statement¹ of

DR. J. STREET BREWER

President

Medical Society of the State of North Carolina Roseboro, Sampson County, N. C.

The organized medical profession of the State of North Carolina is happy to take part in this conference and senses its importance to the residents of this commonwealth. For more than a decade the medical profession of our State, in conjunction with other interested groups and public-spirited citizens, has made an earnest effort to solve the medical care problem as it pertains to North Carolina. It is the view of this profession that the basic problem is to bring the high quality medical care for which North Carolina and America are noted within the economic reach of all our people. This we are continuously attempting to do.

The medical profession has been aware of the economic impact of illness upon the people. Our Medical Society is also proud that through the leadership of the late Dr. Isaac M. Manning, at one time president of the Society, the Society has been a co-sponsor with the North Carolina Hospital Association in the creation of the Hospital Saving Association of North Carolina. This is among the first Blue Cross prepayment plans established in this country to salve the economics of hospitalization required in instances of catastrophic illnesses. * * *

Health Plans for Rural People

It is notable that Blue Cross, as represented by the Hospital Saving Association and by the Hospital Care Association, has developed plans, both of which are available to the rural people of the State. Both plans have shown a vital interest in the enrollment of rural people and are devoting a great deal of attention to trial programs in various sections of the State, seeking the unchartered way toward more coverage for both the low-income rural farm family and the rural dweller's family.

Just now the farm organizations of the State are likewise manifesting an interest in these problems. With their interest and insight, combined in a concerted effort with the health professions and voluntary health service agencies' experiences,

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

surely we as a people will find a solution to a prepayment system of preparing for the major illnesses which tax the even-run of resources from our State wealth which are shared by the average rural family.

Recognizing that the Blue Cross plan was not complete as an answer to the problem of financing medical care during illness, the President of the Medical Society of the State of North Carolina, Dr. W. M. Coppridge, in May 1947 appointed a committee under the chairmanship of Dr. V. K. Hart, which was representative of all the various specialties in the practice of medicine, to undertake to study and to devise a plan of prepayment for medical, surgical, and obstetrical coverage for the lower-income groups.

After several years' study of the various prepayment plans over the country, this committee finally reported its conclusions to the Medical Society of the State of North Carolina at the annual meeting of the Society in May, 1952. The Medical Society immediately launched this plan through the medium of Hospital Saving Association of Chapel Hill as the agent of what is popularly known as the "Doctors' Program" of medical, surgical and obstetrical service benefits to be provided by participating and underwriting physicians for those families having income up to \$3,600 per year.

Rural Health Program

During the years 1947 and 1948 the Medical Society, through the Rural Health Committee—then under the chairmanship of Dr. Fred C. Hubbard—initiated a rural health program involving the surveying of and determination of basic health needs at the grass roots level by seeking out the causes of health deficiencies and finding the interest of the people at the community level in those moves which they regarded essential to the development of good health for the individual.

After a period of manifest interest on the part of doctors in stimulating this activity among people in a few counties, Miss Charlotte Rickman was employed as a health education consultant. Since that time, in 1948, she has aided the Committee on Rural Health to develop health council activity among the people in several counties in North Carolina and assisted the local citizens in establishing health councils.

These activities have gone to the very grass roots, as Miss Rickman has worked in individual com-

munities, learning from the people themselves what their primary health problems are and aiding them to find and develop answers to solve these problems through the medium of their own resources.

The response of the people to her efforts has been encouraging in all areas where the program has been initiated; and the work of Miss Rickman and the Committee on Rural Health has been compatible with the interests of the people. Much planning for better health participation by the people has been accomplished. The success of the activities of the Rural Health Committee is exemplified in the national stimulation of interest in rural health programs, recognized in the recent appointment of Dr. George F. Bond, of our Society, to the Council on Rural Health of the American Medical Association.

Organizations Cooperate and Support

A more recent note of progress in the field of rural health is evidenced by the stimulation to our Committee on Rural Health in the fortunate cooperation and support of an advisory committee representative of rural organization and rural community life in our State, to wit: The Grange, Farmers Federation, State Agricultural Extension Service, Home Demonstration Clubs, North Carolina Health Council (of health agencies), the Farm Bureau, Rural Schoolmasters, Parent-Teacher Associations, Women of the Farm Bureau, Home Demonstration Department, Agricultural Education, and Home Economics Education.

These groups and interests in the rural life of our State have just now joined the efforts of our Rural Health Committee, as an organized group, to broaden the scope of the health care program and to develop the liaison to reach or contact more of our rural people in the general process of ferreting out the basic needs of the community for health projects and to enable the people to discover their own resources and to organize these resources in such a way as to accomplish their health needs.

Personnel, Facilities, Finance

We recognize that there are gaps in the program of bringing adequate hospital and medical care right down to our rural people, particularly the tenant farmer and other segments in the very low income group. The problem of the distribution of medical care is concerned with three basic factors, namely: personnel, facilities and finance.

Very definite progress has been made in the State in the provision of facilities through our hospital building program, with the result of increase in the number of beds, more efficient hospital plants, and modern equipment with which to carry on the important supportive care essential in the medical treatment and care of the sick.

Throughout the Nation, and particularly in this State, marked progress has been made in expanding and extending the facilities and resources for training medical and ancillary personnel. An increase in the capacity of each medical school located in this State has characterized the past decade, and we may expect an increase in available health personnel, professional and ancillary, through the enlarged Medical School of the University of North Carolina, the threshold of a new era in professional education, just this week announced. Moreover, there is abundant evidence of the increased enrollment of medical students and, indeed, graduations of medical students within the current year. North Carolina is not devoid of its part in this march of progress.

We believe that the so-called "shortage of doctors" is more fanciful than real and that a better distribution of medical personnel in this State, and in the Nation, will go a long way toward solving the over-emphasized problem and need for doctors in rural communities.

To invite a physician to locate in a rural community is not enough. The community must be one which is characterized by good living conditions, wholesome environments, and institutions of basic spiritual goodness, as well as one having the economic elements of support of a going medical practice of scientific worthiness.

The rural community must be educated to share in the responsibility of bringing these conditions to prevail in the community. . . . It must be educated to use its physician and patronize his service as an essential service of the community, not to be spared at the expense which attends our desires for the frivolous in recreation and personal-use materials.

The tendency in many rural communities to make use of the physician only in "foul weather" and for emergencies, while gravitating to the cities for "fair weather" or luxury services, is discouraging young physicians from locating in rural areas and is, not infrequently, driving away physicians

already placed in rural areas to specialize and to locate in the city.

Modern Transportation Shifts Emphasis

Let us remember that the advent of good roads, now becoming a veritable network of pavement in rural North Carolina, enlarges the area of service and usefulness of the physician and diminishes the time involved in rendering his services, and therefore increases the availability, quality, and quantity of medical care to the rural population.

Moreover, modern modes of transportation have shifted the emphasis from travel by the physician to travel by the patient to points where more efficient medical service can be rendered, when compared with the former limitation of treatment in the home. For these reasons, let us beware we do not overinduce professional personnel toward the rural centers to the point of diminishing our good standards of rural medical care and invite the compromise which attends the ethical outlook on disastrous competition.

New Drugs Shorten Illness

Let us also remember the influence of the modern miracle drugs. Antibiotic therapy shortens illness and consequently the time a physician devotes to a patient in treating him. As a result, treatment much more frequently becomes a fairly simple office procedure in lieu of previously prolonged home visits in the care of illness of great medical difficulty.

Dr. Johnson and I the other day estimated the time it took us 10 or 15 years ago to treat a case of pneumonia—some 15 to 18 hours. Now we treat the average case of pneumonia in from 30 minutes to an hour or an hour and a half in time.

Financing Medical Care

The problem of financing medical care in rural areas and among low income groups of people, such as tenant farmers, laborers and unskilled workers, is a real one, but in our opinion not an insurmountable one. Rather, it is a challenge to us to use our best efforts in finding a solution. The low income and low health standards of these people make the adjustment of prepayment insurance coverage, in line with their ability to pay, a difficult one. Their ignorance of and indifference to accepting minimum health standards and their high accident rate places them in a different actuarial category from the city dweller and the industrially employed.

The long-range answer to this state of affairs is better and more thorough health education and the improvement of their economic status. These people need insurance at a cost they can afford to pay. Nor would a bounty from an unseen benevolence operate to make this possible. The education of landlords, the farm bankers and the time merchants toward a fuller recognition of their responsibilities and obligations will help to bring these things to the tenant farm family.

An allowance for hospital and medical care insurance coverage, as these families make preparation to secure the "year's run," either in the form of credit or cash from the finances of the landlord, the banker or the time merchant, is an item of essential expense that should be budgeted in the same way as items of food, clothing, fertilizer or crop insurance. This will constitute an ideal and effective way of cushioning the unexpected shock of catastrophic illness.

People Make Real Effort

One thing stands out in the experience of the Rural Health Committee of our State Medical Society, as its health education consultant has gone into the various counties, and that is that the emphasis on the health problems of the people vary widely from county to county—indeed, from community to community.

It is also strikingly evident that the people are anxious for and respond to leadership when stimulated; they have shown eagerness and ability to find their primary problems; they willingly join in any organizational effort to do the things necessary to raise the health level of the community and to work toward the elimination of those deficiencies which involve the health needs of the people.

Sixty-six percent of the State's population is rural; therefore, all interested parties, health agencies, farm organizations, and the health professions should join in a real effort to get rural people, physicians and community workers, and allied group interests, together for a discussion of North Carolina rural health problems so as to point the direction for future corrective effort. Let us remember that good hospital care and good medical care, as necessary as these are, are but a part of the answer to the problem of ascertaining and maintaining good health.

The acquiring of a standard of good health in any community involves a great deal of health

education and preventive measures. For example, although we have been 40 years in the effort, the elimination of the hookworm infestation during these 40 years has done very little toward the prevention of the infestation, despite the planning and agitation from a great many government agencies.

The problem cannot be solved until people are educated and reeducated that to get rid of hookworms involves an effective sanitation program and the wearing of shoes—simple things in which the people must participate themselves if they are to have effect. How can we ever eliminate hookworm as long as thousands of our rural people, by choice, go barefoot April to October?

Negro Is Selfdependent

In concerning ourselves with any facet of health or medical care, we would be prone to caution that the Negro cannot be dealt with as a separate element in the population of our State. While recognizing areas of concentration of these people, their health care and their medical care problems are not essentially separated from other segments or characteristics of our population.

Indeed, the Negro of the area has attained a hardiness of self dependence which very nearly equals any other race or segment of people which populate our State. Certainly in the planning and the extension of health and medical care within our State there has been no conscious effort to differentiate, and the Negro family shares in the good health moves in our State in proportion to choice and effort which all of the people undertake to decide for themselves.

Conclusion

In conclusion, we can cite the definite progress which has been made during recent years in bringing a better distribution of health care and medical care to the people of North Carolina—and we believe an ultimate solution will be found in our effort to fill the gaps. We believe the problem will be solved by evolutionary measures, through the earnest efforts of all concerned—the most important of which is the concern of the rural people of North Carolina for which it is noted. We have faith in the combined capacity of these people when stimulated and activated in the true democratic processes of helping themselves to better health.

Statement¹ of

DR. OSCAR P. HAMPTON, JR.

President

St. Louis County Medical Society

St. Louis, Mo.

We believe that in St. Louis County we have exceedingly adequate facilities including professional personnel, for medical care of our citizens.

There is no shortage of physicians. Anyone who has reasonable means with which to secure private medical care can get it and can get it promptly.

We have in effect an emergency call system arranged principally through the local chapter of the American Academy of General Practice in which our physicians participate, so that there is someone on emergency call at all hours of the day, every day in the year, and can be reached for professional care on a private basis.

At the St. Louis County Hospital we have more than adequate facilities for the care of the medically indigent. St. Louis County Hospital is not a large charity hospital. Its total bed capacity is something over 200, yet it has been running for several years at a capacity seldom exceeding 60 percent.

That is the census; it seldom exceeds 60 percent. With those statements it seems reasonable to conclude that anyone in St. Louis County can promptly obtain adequate medical care for any acute injury or acute illness.

We do have, however, some deficiencies. An outstanding local deficiency is inadequate first aid on the roadside. That is a problem that is now before the county council, a problem which several organizations have been considering.

We need better ambulance coverage of St. Louis County. We need better first aid at the site of the accident by ambulance and law enforcement personnel.

This, I point out, is the problem of the political subdivision of the county and its municipalities, not a problem of the medical profession.

Another deficiency is the lack of facilities for the mentally and chronically ill, the tuberculous, the aged, and the infirm.

We do not have anywhere near adequate facilities for these groups. The problem is being con-

sidered and being worked upon at the local level in the county. This, however, is the responsibility of the State of Missouri.

I am informed that it is provided in the constitution of the State that facilities must be provided for this group of people who need institutional care and medical services. This is not a problem of the Federal government, but it is a problem of the State and of the local subdivision, in this instance, St. Louis County. With that summary I believe I can state that from the standpoint of organized medicine in St. Louis County we are adequately covered for the acutely ill and the acutely injured; we are deficient in first aid and in facilities for the mentally and chronically ill, the tuberculous, the aged and the infirm.

Statement¹ of

DR. RALPH A. JOHNSON

President-elect

The Wayne County Medical Society

I am president-elect of the Wayne County Medical Society. I should like to emphasize as strongly as I can that I am speaking as an individual and not as the official spokesman of the Wayne County Medical Society.

It is my belief that the best government is the government that thinks always: What is best for our people?

That is the one criterion on which we must judge all things, and that is the common meeting ground you and I have today. In the brief time that is allotted to me, I should like to give this Commission the results of the experiences of the practicing physician.

This Commission is gathering testimony on the health needs of the Nation. Other physicians will demonstrate the needs in most of the important areas: Hospital construction, nursing, medical education, and the others that are not just local, regional, or national—they are universal.

Certain well-intentioned people believe that a system of governmental control of the practice of medicine—which I shall refer to hereafter as compulsory health insurance—is a health need for this country. Others, and I am one, equally strongly believe that the present system must be preserved. For this system enabled the United

¹ Delivered at the Regional Hearing in St. Louis, Mo., September 15, 1952.

¹ Delivered at the Regional Hearing in Detroit, Mich., September 23, 1952.

States to become not only the healthiest, but the best Nation, under God on this earth.

What has happened to the noble ideals of the medical profession? Almost since its beginning practitioners of the healing art have been a dedicated group of men and women. They fought for many health measures, so that a sage once remarked "The medical profession seems to be working diligently to do themselves out of a job." Are we, the inheritors of this glorious tradition, false to its ideals? Are we opposing compulsory health insurance for narrow and selfish motives?

No.

Let me prove my contention by citing aspects of compulsory health insurance that afford a distinct advantage to the practicing physician and thereby bring forth an opposing disadvantage to the patient who has to have a doctor of medicine for himself and family.

For the sake of argument—if compulsory health insurance could give a better, a broader and a cheaper service for all of the people—then it must and will prevail. But can it? Legislation is of no telling effect in preventing many ailments. The tubercle bacillus responds only to the laws of nature, not to the laws of man.

Doctors "On Call" 24 Hours

Under the present system of medical practice, most doctors are "on call" 24 hours a day. Rightfully our patients expect us to respond to their request for service. Affliction refuses to be confined to a time, place or even a convenient factor to the patient or the doctor. In certain emergency cases it is wiser to have the patient brought immediately by ambulance to the hospital.

This action saves that time that could be the factor between life and death. For the doctor to go to the bedside to verify need can expend vitally precious minutes. It would be utopian for the doctor of medicine to respond, in fifteen minutes, upon any and every occasion when he was wanted. Wanted, you observe, not needed. Doctors are working hard and for long and heavy hours, and uniformly with diligence and a desire to help and please their patients.

What would prevail under compulsory health insurance? For one thing—a type of 40-hour week, time off, vacations and assured salary and a less pressing need to please each patient.

By the very nature of things there would be a shortage of medical man hours, perhaps. The up-

swing in demand for service—its "free" nature would change the existing minimal shortage of doctors of medicine to a critical one.

The Competitive Factor

Under the free enterprise system there is competition between physicians. This is healthy. Let me illustrate.

When I come home at night, after an evening at the theater, and observe the light on in the library of my next-door neighbor, who is my very good friend and a very real medical competitor, I hope he is reading a detective story. I am quite sure, however, that it is more than likely he has been keeping abreast of medical literature. The edge of the pleasure of the evening is dulled. This is a healthy thing, not only for me, but for my patients.

There is, then, more than curiosity urging me to keep up on this increasingly complicated and increasingly interesting job—the practice of medicine. The importance of the competitive factor in the growth of America is too well known for me to dwell upon it further.

Under compulsory health insurance there will not be this element of competition between physicians because we will all be working for the Government. Today we are all working for the patient who employs us. Under the other system we will all be working for a common employer. I should like to particularly stress that point; I should like to underline it, because to me it is the single and most important point I shall strive to make. Its complications are serious and should cause real concern.

Choice of Physician

Unfortunately, in the time allotted to me I cannot illustrate the many facets that this point makes. Let me illustrate this by this example. We all know of instances where an individual, covered by insurance for an accident or illness, prefers not to go to the company doctor, but instead to pay his own physician for care and medical attention and for the satisfaction of knowing that his doctor is working for him.

Competence is not an issue. The company physician is as competent, perhaps more so, than the physician chosen by the patient. But the fact that the company doctor is working for the company and not the patient is sufficient to turn the patient away from seeking his services and to pay the expense of seeing and having the physician of his choice.

The Minister of Health in England exercised this privilege when he had his hemorrhoids removed. The operation was done by a private physician—not a doctor under the British panel system. Can there be any more biting indictment of compulsory health insurance?

Under compulsory health insurance I will be given the instruction not only of what to do, but how to do it, and not by someone who has the advantage of seeing the problem that I am facing, but because it is a directive. The judgment of the doctor faced with the immediate problem becomes secondary. Treatment then will become standardized.

It is my conviction that standardized treatment is inferior treatment. No one can persuade me away from the observation that each man, woman and child is a separate and distinct entity. They are individual. They are custom-made. Of course we all have many traits in common. Of course I have a standard of treatment, but you must realize that these are principles of treatment, and of necessity the application of these principles varies, and varies widely. This can be confirmed by the observation made many years ago that "One man's meat is another man's poison."

Entrance of the Middle-Man in Medical Practice

Another facet that will come in under compulsory health insurance that does not exist today: there will be a middle-man between the patient and the doctor. We all remember the trials and tribulations of rationing boards. These were a necessity during the war. But rationing then was a national emergency, that was a period of precedents. Rationing was required because of a shortage of civilian goods. So that each might share equally in the rationing board's scarcity of civilian goods, these boards were required. Rationing boards will be required should compulsory health insurance prevail.

Now the ideal that these laws intend to attain is a worthy one. I have no quarrel with it whatsoever. Personally I should like to see this become a reality. Under this lovely ideal the patient would go to the physician of his choice, obtain the necessary treatment, and have the expense deducted from his pay check in part, his employer in part, and all the rest of us—in part. There would be no catastrophic loss to him because of illness, yet the physician would be remunerated. It would be a mutually satisfactory regime.

It would be everything, but possible and workable. Why? Because that will not be the reality. No one can write a law that will make it a reality. They may, and do think that they can, though. The reality is vastly different. The reality is this: Ration boards, inferior care and bureaucratic control.

How can I be so certain, when I (personally) have not had the experience of living under this type of regime? Well, the pattern of the past is a pretty good index to use to judge the pattern of the future. Any and everywhere that compulsory insurance has been tried, it has resulted in the reality as I have depicted. It was true in Germany under Bismarck, in England, in New Zealand and everywhere that the principle of compulsory health insurance has been undertaken on a sweeping governmental scale.

The Private Practice of Medicine

In summary then, the private practice of medicine today parallels the lines of free enterprise and its competitive system. The system that permitted industry, sciences and the arts to grow abundantly. This condition resulted in the United States becoming the most prosperous, the healthiest, and the best country in the world. Fortunately for America, regimentation and governmental bureaucratic control have been kept at a minimum. There will always be a need for some governmental control. But not, pray God, that kind that destroys the principle of free enterprise, the rights of the individual, all the blessings we share as citizens of the U. S. A.

Chairman KENNETH B. BABCOCK. Thank you, Dr. Johnson.

Failure to Lead Creates Vacuum

Commissioner WALTER P. REUTHER. I would just like to make this observation. I agree with most of the fine sentiments Dr. Johnson has expounded here. I would like to just point out that there are many people in America who do not believe the choice is between what we have or compulsory health insurance. We believe that there is room for a great deal of improvement and strengthening of what you call voluntary medicine. We also believe that unless the people in the medical world who obviously know more about medical problems than do nonmedical people give more positive leadership rather than negative leadership, you will get political decisions in the

field of medicine because of the vacuum that the failure to lead creates.

I think that the doctors have got to lead more if they are going to solve this problem of how a free people find a way to satisfy the medical needs without the politician getting involved.

I am reminded of the fact that only a few years ago in the State of Michigan, the medical profession was fighting tooth and nail against Blue Cross; because I remember meetings I had in Genesee County with the county medical group, and when we begged them to participate in Blue Cross we had only one doctor, and a week later he was blackjacked out of it.

We went up there and we had to talk with them about this thing, not only as a matter of meeting human needs but as an economic matter. It was only when we threatened the economic position of the doctors did they respond and then they began to get into Blue Cross.

I use that to illustrate what I think is the negative attitude in this. The answer to this problem of avoiding political decisions in the field of medicine is for the medical people to give the leadership so that the vacuum is not there for the politician to fill.

Dr. JOHNSON. Thank you, Mr. Reuther. I would like to have made that point myself although not quite as ably as you have.

Statement ¹ of

DR. JOHN E. McDONALD

President-elect

Oklahoma Medical Society

Tulsa, Okla.

My name is Dr. John E. McDonald. I am a practicing physician in Tulsa, Okla., and I appear here today representing the approximately 1,600 members of the Oklahoma State Medical Association. I am the president-elect.

I am firmly of the opinion that the majority of physicians in Oklahoma feel that basic health and subsequent mortality and morbidity rates stem from the everyday life of the individual. Yet no place in the study of the Commission at this hearing is there any mention made of the problems of housing, home sanitation, or adequate food and clothing.

Certainly the high prices of today, particularly on food commodities, are causing many persons, including children, to be denied basic body-building food due to their inability to pay for such food commodities. The price of a pound of steak, a dozen eggs, and a quart of milk is sufficient example of this comment.

Statistics on housing and home sanitation which are available to the Commission from the Department of Commerce would likewise be very revealing. I would also call to your attention that there is nothing in the study with regard to the death and injury rate and impact on health facilities and personnel and on the family life of persons killed and maimed yearly by accidents on the highways and elsewhere. Certainly if we are to study and consider shortages in health personnel and facilities, these basic problems are just as important as medical research, application of new medical techniques in the diagnosis and treatment of heart disease, cancer and tuberculosis, etc. A physician in every block and a hospital in every hamlet, town or city cannot reduce the cost of food, improve housing and sanitation, or make people more careful in their driving habits.

Health Personnel Shortage

Problem No. 1.—“Current Shortage in Health Personnel.”

This question is to me like the yearly headlines in Oklahoma, Kansas, and elsewhere which state: “Shortages of Box Cars to Move Wheat.” While there may be a shortage of boxcars to move wheat on a given day, does it mean that the Nation as a whole needs more boxcars? If it could be agreed that there is a shortage of health personnel, what is the reason for such shortages? Are we studying for the normal time, wartime, police action time, or just presenting a situation to maintain tension? Let's look at some of the facts:

Today there are, in my opinion, four major users of health personnel as follows:

1. The general public.
2. Government (exclusive of military).
3. Military.
4. Industry.

To discuss this breakdown, let us look at Oklahoma. For a population of 2,230,756 we have 2,033 physicians who held licenses to practice in the State in 1951, or an average of one physician for each 1,090 persons. The Legislature of the State of Oklahoma, without any Federal assist-

¹ Delivered at Regional Hearing, St. Louis, Mo., September 15, 1952.

ance, has appropriated sufficient money to increase the freshman class at the medical school from 54 in 1949, to 80 in 1950 and to 100 for the last 2 years—an increase of almost 100 percent. It can hardly be stated that these figures represent a shortage.

Distribution of Physicians

The next question, of course, is that of distribution. It would not be factually honest to say that there was equal distribution. The economics of present day American life, the automobile, good roads, etc., have caused the disappearance of physicians from some small communities, just as it has caused the disappearance of the small bank, the general store, the lawyer, and, in some instances, the church.

It has been interesting to note, however, that from the 1950 graduating class of the University of Oklahoma School of Medicine a survey showed more students indicating a desire for general practice in communities of 5,000 or less than in any other field. But notwithstanding these facts, let us look elsewhere for a part of our answer to health personnel shortages.

The Hoover Commission in its report found 44 Federal agencies dealing with health and spending \$1,250 million against \$250 million in 1940—a jump of 400 percent. Either this increase by the Federal government in health programs was taking a large amount of trained health personnel or the programs were being directed by untrained personnel. Consider from this same source the report that the Veterans Administration, with a surplus of beds, is building \$1 million worth of new hospitals—that in San Francisco even though there are 13 government hospitals, new ones are being built; in Houston, Tex., a \$25 million hospital was being built next to a Navy hospital, with only 10 percent of its beds filled.

These illustrations are given to point up the question as to whether there is a shortage of health personnel or a wastage of personnel, with one of the prime violators being the Federal government. I ask the question—would there be an assumed shortage of health personnel if veterans were hospitalized at or near their homes in hospitals of their own choice, and treated by the physician of their choice? Can it be said that they would get inferior care in their local hospitals when the average stay for a patient in a private hospital is approximately 8 days, in a county hospital approximately 17 days and in a Veterans Administration hospital approximately

30 days? Could not the same personnel serve both the government patient and the public at large?

The Military Forces

Consumer No. 3, the military force, is entitled to whatever personnel, in whatever numbers are needed to give the maximum health care to our boys and girls serving their country. But are we to assume that we will never have a changed condition military wise? Should not the average American be willing to make some sacrifice so that the health personnel now serving in the military forces can hope to return to reasonable prospects of employment, rather than return to find the health care field so completely over-expanded that they can only hope to face possible unemployment? It is my opinion that if the physicians, dentists, nurses, dietitians and physical therapists, etc., now serving in the armed forces were reduced to a secure peace-time army strength, there would be a different picture painted as to health personnel.

Industry

Consumer No. 4, Industry, must, in order to meet mounting insurance and compensation costs, develop safety and first-aid programs, and in these instances there has been created a demand for health personnel not present 10 to 15 years ago; but I am wondering if in many cases these programs have not become deluxe rather than just maximum?

My conclusion is that instead of an actual shortage of health personnel there is an unreasonable waste of health personnel, with government being perhaps the prime violator.

. . . Good sound public health long ago proved its place in American health life. However, its field of coverage should be limited to preventive health measures, and financing should be on the local level to the greatest extent possible. No city, county or state unit of government can factually assume it is operating on an economically sound basis or in a businesslike manner when it accepts the return from the Federal government of its citizens' dollars watered down 60 percent.

The development of State and local health councils, wherein citizens of a given community band together for better health in their community, have done more at infinitely less cost than government subsidized programs.

In Oklahoma, a State which did not come into the Union until 1907, 48 counties out of the 77 have

full-time public health units, and the balance of the counties, through their elective county commissioners, have chosen to place the tax dollar elsewhere than in a full-time public health unit. Unless we assume that the people cannot do for themselves, it would seem that any other form of compulsion on a local community would border on being un-American.

This comment, however, should not be interpreted to mean that such communities should not have educational programs directed to them on the advantages of full-time public health units. These observations, of course, are not to be considered to cover disasters and outbreaks of epidemics.

Medical Research

... It is my opinion that at the present time medical research is progressing at a pace beyond our fondest hopes. It is my further opinion that research must be free and unhampered. Certainly in isolated fields, such as atomic research, there must be some government subsidization. On the other hand, if the Federal government would give tax relief to corporations, businesses and individuals for contributions given to approved research, private funds in almost all instances would be sufficient to finance almost all worthwhile medical research. The history of the world has never shown that government has succeeded where private initiative has failed.

It might be of interest to the Commission to know that in the State of Oklahoma there has been established the Oklahoma Medical Research Foundation. This Foundation was created by the everyday people of Oklahoma who have given in excess of \$3 million, and of that sum \$1 million was pledged by the physicians of the State. This Foundation and its modern building and faculty is now a world-wide example of free enterprise in medical research. Should any of you be thinking of Oklahoma as a state of oil wells, may I point out that according to the Department of Commerce in 1949, Oklahoma was the 39th State in the Union in per capita wealth and the contributions which created this Foundation came from every county in the State.

In summary I would say that government has a definite place in research, but not a place of domination.

Hospitals and Clinics

The degree to which hospitals and clinics meet existing needs: Due to the fact that I am unable to

determine the Commission's definition of "clinic," and because in reality I am of the opinion that the subject of clinics is of relatively little importance except in teaching institutions and metropolitan areas, which we do not have in Oklahoma, I will comment on hospitals as they serve the people of Oklahoma.

Oklahoma has a total of 164 hospitals licensed by the State Health Department. Of these 164 hospitals, 122 have 49 or less beds; 27 have from 50 to 99 beds; 11 have 100-199 beds; and 4 have 200 beds or over. This is exclusive of federally owned and operated hospitals. The 164 hospitals of Oklahoma have 7,066 beds, 1,568 bassinets. Their average percentage of occupancy is 65.7. Total patient days in 1951 were 1,442,566, and patients admitted were 247,458, and the average length of stay 6.05 days. Of Oklahoma's 77 counties, 64 have hospitals, one other county has voted bonds. Considering available hospitals in bordering States as well as Oklahoma hospitals, no Oklahoma citizen is over 60 miles from a hospital and exclusive of one county, the distance is reduced to approximately 35 miles.

While these figures are encouraging and represent community planning, these or any other hospitals cannot stand a Federal program to give free hospitalization to all persons over 65, which is being proposed by a certain Federal bureau. Hospitals are for the sick and not domiciliary homes for the aged whose families want to chuck their Christian obligations.

Health Insurance

The extent to which people are able to afford adequate medical care, with particular reference to present health insurance plans and their adequacy:

In studying the six major points to be heard at this meeting, I am of the opinion that it is this question which will bring the widest differences of opinions between those who believe in the free enterprise system and those who propose Government control of health care.

Right at this point I should like to make certain that the Commission fully understands that in Oklahoma voluntary prepaid insurance is available to any person who is willing to protect himself to the extent of the price of a package of cigarettes a day or a milk shake from the corner drug store. Blue Cross and Blue Shield plans, as

well as the commercial companies, have extended their coverage to this extent.

* * * * *

While national figures are available to the Commission, may I cite certain conditions as they pertain to Oklahoma?

Oklahoma is a state of 2,230,756 people, homogeneous in origin, and generally considered rugged individualists. For this group of 2,230,756 people, what is the exact situation concerning availability and cost of medical care?

In considering this question, I believe we would find these three major segments of the population.

1. Indigent
2. Sustaining income
3. Economically independent

Indigent Population

Considering the first group, the Constitution of the State of Oklahoma provides that the County Commissioners shall provide for the care of the indigent. In addition to this provision, the Crippled Children's Act for the State of Oklahoma provides that any person up to the age of 21 is eligible for medical care, for any cause, when certified by the proper authorities. Add to this the care provided free of charge by physicians and hospitals, and there is no excuse why this group of people should not be receiving medical care. I am also of the opinion that no Federal program can materially change this condition.

Sustaining Income

For the second group, which is the greater portion of our population in Oklahoma, there are interesting statistics.

In 1951 there were 383,679 persons covered by Blue Cross and 266,515 by Blue Shield, and in 1952, Blue Shield figures almost equal Blue Cross's. In a recent survey by a large Oklahoma city hospital of 1,000 admittances, the survey showed within 1 percent as many persons had commercial coverage as had Blue Cross and Blue Shield. On this basis approximately 750,000 Oklahoma people have protection against illness. Add to this the approximate 300,000 Indians who have Federal care and disregarding care given by the Veterans Administration, and you are close to one-half the total population of Oklahoma. It should also be kept in mind that this growth was principally between 1940 and 1951, and the rate of growth is still continuing.

Economically Independent

Group 3, it is obvious, can handle their illness obligations in their own way and should be privileged to do so.

While I do not hold myself out to be an authority, I am firmly of the opinion that any counter-proposals for Federal control of health care will not only be more expensive, but of vastly inferior quality.

Obligation of the Individual

The second part of the question deals with the adequacy of these programs. In my opinion this begs the question as to whether they should be all inclusive or follow the proven principle of the insurance deductible formula. While any of us would like all of our bills paid, I am firmly of the opinion that no program, either of government or of a voluntary nature, should be so constructed that the entire obligation of the individual citizen becomes the responsibility of another party, person, or government. While I do not oppose the expansion of these programs in their coverage, I nevertheless believe they should be actuarially sound rather than made a cradle-to-grave contract, waiving individual responsibility.

I have appreciated the opportunity of appearing before the Commission but regret that from one day meetings in various parts of these United States any Commission, irrespective of its appointment, will attempt to come to conclusions on such important questions as are herewith being discussed.

Role of Public Hearings

Commissioner EVARTS A. GRAHAM. I am sorry to cut you a little short, Dr. McDonald, but you know we have a long program ahead of us.

I would like to say also, for the benefit of the others, that this public hearing today is not the only source of information that the Commission has been getting about many of these facts. There is a permanent staff of the Commission that is working continuously acquiring the facts, and the Commission has very frequent meetings at which we have people come before us to present the facts in their respective fields.

We have interviewed many, many hundreds of people, as a matter of fact. Those were mostly on the basis of the national level.

The purpose of these public hearings is to get the facts on a more nearly local level and, of course, the material which is presented often is

similar or almost identical to what has already been obtained on the national level.

For instance, when Dr. McDonald speaks about accidents as an important matter pertaining to public health, we have figures on accidents. We know, for instance, that there are 1,100,000 maimed on the highways every year by automobiles alone, and so on.

We just do not have time to go into all of these things in a meeting like this. Now, perhaps some of you might say, "Why don't you have a public hearing that lasts a week?" Well, because everybody gets tired, and it just seems to be an impractical thing to do.

Statement¹ of

DR. WILLARD A. WRIGHT

Representing North Dakota

State Medical Society

Williston, N. Dak.

My name is Willard A. Wright, and I am engaged in the general practice of medicine in Williston, North Dakota. I have practiced medicine in and around this area for 27 years.

I am here to represent the North Dakota State Medical Association. I am also a member of a good many other medical organizations, including the State Board of Medical Examiners, the American Medical Association Council on Rural Health.

It is my opinion that the people of North Dakota are presently receiving very good medical care, and by any reasonable standard the health and general living conditions of the people of North Dakota is excellent.

Good Care Available to All

Under the existing system of practice and distribution of physicians and hospital facilities, good average medical care is available to all the people of North Dakota. In point of fact, there are very few people who are more than one hour away from medical services. This, I believe, would compare quite favorably with the availability of services in any large city.

Many years ago, when there were a large number of doctors scattered around in small towns and the patient was mostly seen in his home, we encountered numerous cases where illness had been

neglected and allowed to develop into a serious situation before medical help was called for.

This we seldom see at the present time. It is extremely unusual to see a patient with advanced neglected disease. In fact, we get our cases of appendicitis, perforated ulcers, fractures, and other acute emergencies at a much earlier stage than is the case in many cities. People know that by going to one of the recognized medical centers they will be assured of care, and modern types of transportation make it quite possible for them to get there.

I would like to emphasize that this method of providing medical care results in better care at lower cost, and is available to everyone in the state, regardless of their economic standing.

While modern methods of medical care are much more costly than those previously in use, they have resulted in shorter periods of illness, shorter periods of treatment, and shorter periods of hospitalization for many diseases; this has in fact reduced the overall cost for many acute diseases.

Statement¹ of

DR. J. J. MONFORT

Secretary

Arkansas Medical Society

Batesville, Ark.

I am Dr. J. J. Monfort of Batesville, Ark. I appear before this hearing as a practicing general surgeon and represent Arkansas' doctors and their organization, the Arkansas Medical Society, as its secretary.

Current Shortages in Health Personnel

We have 1,373 licensed physicians in Arkansas—one doctor for every 1,390 people. Arbitrarily using 1,500 as dividing point between small town and rural community between 1947 and 1951, 58 doctors (Arkansas Medical Society members) located in rural communities; and from August 1951 to August, 1952, 19 doctors—a rate increase of 35 percent more in the past year than in the 4 years before that. Rural people can now get to a doctor faster from 50 miles, thanks to better roads and transportation, than they could from 10 miles when I first arrived in Arkansas 16 years ago.

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

¹ Delivered at Regional Hearing, St. Louis, Mo., September 15, 1952.

This increase is due to the natural saturation point of doctors in larger communities—rural practice is now more attractive. This will be enhanced by the policy of the Arkansas Medical School's plan of placing "preceptors"—senior medical students—in small towns for eight weeks as part of the curriculum. With a very few more years of time, laws of supply and demand will take care of the alleged "doctor shortage." Our office has carried on an intensive campaign for four years to learn of all areas in Arkansas needing physicians—the most we have been able to obtain have been 38 locations, and obviously some of these are too small to adequately support a physician.

Nursing

The nurse shortage in some areas is acute. The State Health Department points out that it needs many more nurses if its local public health units were to be staffed in a satisfactory manner. And yet it must be said that the Federal government itself is greatly responsible for part of this nurse shortage—for what community or private hospital can compete with the Veterans Administration, for example, with its nurses' salaries sizably higher than that paid nurses giving a like service.

Public Health Units

Our State Department of Public Health informs me that, while the few units we have are doing excellent and admirable work, it needs, based on the U. S. Department standards, at least 30 full time Public Health Service doctors; at present we have only six, and five of these are over 65 years old. The answer? Higher salaries and other inducements for one. They also tell me that it needs 300 nurses, and we have only 104. At present, the State has 57 counties divided into 12 health districts; there are 8 single counties and two cities that have their own health departments. Only 15 of these local health departments are adequately housed—the rest use small rooms in basements and top floors of County Court Houses.

However, it is our belief that what we have is well organized, and that the communities receive far more than a dollar's worth of prevention and treatment service for each dollar spent. But we still need more doctors, nurses, sanitarians, and educators.

Research

The present status and adequacy of medical research in Arkansas is receiving a tremendous boost in the building of our new medical center—a

\$5 million plant of our new medical school and university hospitals, in close connection with our State hospital for nervous diseases. Our present medical school received \$15,000 for cancer research from the American Cancer Society and National Institute of Cancer Research last year and this year, and next year should receive even more, as we expand. This is just an example of our growth in one field alone, compared to 10 years ago, when almost no research was done. Better income would attract more students into research, we are sure.

Hospitals

Degree to which hospitals and clinics meet existing needs is a question quite debatable. While 17 hospitals have been or are being built in Arkansas with Hill-Burton Federal Funds since 1948, we still need more hospitals with better distribution. As with doctors, time will solve some of the problems as better roads occur.

Some areas in Arkansas are not well populated, and in those areas small hospitals are feasible. But, I must call attention to one area in north central Arkansas—a town of 6,000 people. It has 3 privately owned hospitals, with a total of 100 beds—which supplies hospital and medical care for 3 counties. All of these have made small to moderate profits in the past 12 years.

Health Insurance

The extent to which people are able to afford adequate medical care, with particular reference to present health insurance plans and their adequacy, is another debatable point. Nationally, over 80 million of our people have some form of hospital or medical insurance. In Arkansas our Blue Cross—Blue Shield plan is of very recent vintage. We are proud that even though it is one of the newest Blue Cross plans, over 20,000 persons are enrolled—this in a rural State, mind you. This is Blue Cross alone, remember. I have not had time enough to get statistics from the 109 insurance companies that sell hospital and medical coverage insurance in Arkansas.

As a general surgeon, I can definitely state that 5 years ago only one person in five having elective surgery had hospital insurance—now it is three out of each five, in our own group practice. The voluntary approach not only educates the people to protect themselves voluntarily against the costs of illness, but also requires the individual's acceptance of the responsibility to pay for this type of

protection, which is exactly opposite to that of the compulsory program.

As best I can determine, about 20 percent of our rural people are indigent or border-line indigent. The State has a welfare act that relieves most of this 20 percent, although in some areas this is badly abused, due to "politics as usual."

The adequacy of coverage? I can only give you the statistical figures of the past three years: Blue Cross covered 78 percent of bills presented; Blue Shield 69 percent; as of July, 1952, benefits have been increased so that 85 percent of hospital bills will be covered, and 90 percent by Blue Shield.

Conclusion

In conclusion, may we make these points:

1. We are in hearty agreement with the Commission in its efforts to survey the health needs of the Nation, but are forced to conclude that the Commission cannot complete its responsibilities in the time limited—how can the needs of 2 million people be adequately presented in 10 minutes?

2. Arkansas is solving its doctor shortage rather rapidly, also its hospital shortages. But we need more work on the nursing and public health personnel shortages.

3. Medical research is on the upsurge in Arkansas.

4. Voluntary health insurance is rapidly filling the needs of 80 percent of our population—but more help and work are needed at the State and local level—not Federal.

5. Again, State and local health programs in Arkansas are meager but growing—we need more from these levels—not from the Federal government.

6. We hope this Commission will continue its work beyond January 1, and are requesting the two major presidential candidates to do so.

Statement¹ of

DR. J. WILLIAM WRIGHT, SR.

Indiana State Medical Association

Indianapolis, Ind

I am J. William Wright, Sr., a practicing physician of Indianapolis, Indiana and president of the Indiana State Medical Association, and I am here in that capacity today.

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

In interpreting this subject of "health needs" everyone can place a different interpretation upon the phrase, but it should be stated here that there shall always be "health needs" irrespective of measures taken to solve them. We shall always have with us a group which will not practice good health habits, even if the facilities were free, the same as we shall always have those among us who will not work at gainful employment even though it might be offered them. Therefore, we should admit, the health needs of the Nation can never be completely solved, because the public will never permit their being solved in all respects.

I can say without fear of contradiction, there has been no group which has evidenced more interest in the health of the people of this Nation than have the physicians and the medical research scientists. Some would differ with this statement. Taking into consideration the remarks which have been made previously before this Commission, and the remarks yet to be made, together with the known facts now on file with the various departments of government, provides conclusive evidence of the profession's sincere interest in the health of our people.

Unfortunately, those who would criticize the profession do so on limited authority. It has seemingly been the pattern of events during the past few years to select those few instances where there is room for legitimate complaint and charge the whole profession with the guilt of the wrongdoings of a few. Yet, I dare say, there is not an organization appearing before your Commission in which similar examples of neglect (or whatever term you might choose to call it) cannot be found among the membership. Therefore, we feel that a more honest appraisal of the facts should be made in the belief the advancements and the good accomplished will far outweigh the unfortunate.

In our opinion, Indiana is an average State; it has long been recognized as the center of population for the Nation. It is composed of all races and creeds, it is both industrial and agricultural; in fact, we have been considered as a true cross section for many studies made by many organizations.

Indiana, too, has a reputation for solving its own problems, without the necessity of outside interference. We in Indiana—and I feel I speak for the citizenry as well as the profession of medicine in making this statement—feel it is still our

God-given right to chart our own course and resolve our own problems in a manner harmonious with our way of life.

I note your Commission has been charged with the responsibility of surveying "Current shortages in health personnel".

Health and Medical Care

In referring to the medical profession, I would like to make it clear there is a difference between health and medical care. Health is a matter of individual responsibility, while medical care is a purchasable commodity. Health is not a commodity that can be purchased with money; health is something only the individual himself can control. Some are endowed with good health, while others less fortunate are created with poor health, and in many cases, no matter what is done, the health cannot be restored. If a physician prescribes health-giving measures and the patient fails or refuses to follow these recommendations, then poor health is the fault of the individual and the individual only; legislation will not change this picture.

The medical profession was the first organization concerned with the subject of health. In Indiana, as has been true in most States, the establishment of our State Board of Health was through efforts made by the medical profession. Indiana is proud of the fact the medical profession of our State was responsible for establishment of the first food and drug act in the Nation. In fact, the Federal government has adopted almost word for word the Indiana law.

Without exception, every organization presently working in Indiana in an effort to bring better health practices to the people of our State, either through assistance of one form or another, or through programs of education, can show the medical profession as one of the first supporters of these programs, that physicians are closely allied as members of their board of control, or active in assisting in carrying on their programs.

Training Additional Physicians

There is a wide variance of opinion of what constitutes adequate health personnel or what constitutes a shortage of personnel. If, in this case, you are referring to physicians, we do not believe there is a dire shortage of physicians in Indiana. The physician population ratio for Indiana is well within the national average.

It is a fact that the training of physicians in our State has shown a marked increase during the past few years. Our State school, originally planned to train 86 physicians per year, has for the past several years been training 150 per year, and now ranks fifth in the Nation. It is true, we need more modern facilities for our school, but this problem is being solved by the people of our State.

In 1951 the legislature granted \$125,000 for the purpose of blue-printing and planning a new medical training center anticipated to cost somewhere near \$6 million. This sum, it is expected, will be granted by the 1953 legislature.

During this period of forced inflation, our school has suffered because its dollars would not go as far. The physicians of Indiana, during the first 6 months of 1952, voluntarily contributed over \$50,000 to assist the school through this difficult period. These gifts have permitted the school to maintain salary scales in keeping with the times and permitted the filling of chairs which otherwise might have been left vacant. This effort on the part of Indiana physicians is not a one-time shot—rather, it is geared to multiples of 3 years.

Rural Shortages

There are those, too, who claim there is an urgent need for more physicians in the rural areas. The greatest problem we have here is the fact that present government demand for medical personnel does not leave sufficient men to begin to fill some of these purported needs. Yet, in spite of this, there is no person in Indiana suffering from lack of medical attention if the need is made known.

Again, as we discuss the so-called shortages of physicians in the rural areas, we feel there are other shortages in existence also. For example, what has happened to the general stores that dotted the countryside just a few years ago, the hardware stores, etc.? Lack of utilization of these facilities by the residents of rural America has driven them out of business.

As transportation has improved, the people have been inclined to travel to the larger centers for their needs, including medical care, and no longer will utilize their local facilities, only when it is inconvenient for them to travel to the larger centers for their wants. Therefore, it becomes a problem for anyone to fulfill the need for any facility as a matter of convenience.

Our economy today demands a person take in a sufficient amount to permit his existence. Therefore, medical men, too, have migrated to the larger centers where the public travels to transact everyday needs. If the reverse were true, we would not have a shortage of physicians in any community, nor do we have such today, in face of the above facts. We can, however, agree we may have a maldistribution, but this could be solved overnight, if the public itself would change its habits and return to the practice of depending upon neighborhood communities for its wants.

Public Health

Indiana has an abundance of health personnel, should you consider those who are working in the field of health either in gainful employment or on a voluntary basis. If we could estimate the number of people involved in the active work and educational effort of our various agencies, both official and voluntary, then Indiana could cite the ratio of health personnel as being approximately one person in every four.

If you interpret adequacy of local public health units as meaning every community should have a full-time health department staffed with a large corps of specialists in every phase of what we accept as basic essentials of health, then a shortage does exist in Indiana. However, every county in our State has either a full-time or a part-time health department. Many counties have functioning health councils comprised of those skilled in the field of health and the public at large.

Indiana has legislation on the books providing for health departments at the local level, as elaborate as the community might desire. However, few communities have felt they needed a full-time health department and have so signified by their ballots. In other words, Indiana communities properly have the right to determine by ballot their desires in this field.

Research in Indiana

The present status and adequacy of medical research—Indiana of course does not have the elaborate research centers to be found in other sections of the country. Nevertheless, many research projects of note have been and are being carried on within our State. We are the home of one of the world's largest pharmaceutical manufacturers, Eli Lilly and Company. This firm alone has developed many items which have proved helpful to millions of individuals through-

out the world. They have been responsible for many drugs which have enabled the span of life to be increased.

Research is constantly being carried on in our large university hospitals and in laboratories throughout our State.

Hospital Facilities

Today every community in our State is within easy reach of good hospital or clinic facilities. In a recent study there was no community in the State which did not have at least one hospital facility within a radius of 20 miles. Indiana communities have been alert and have constructed hospital facilities where they felt they were needed to provide more accessible care. One thousand seven hundred and thirty-six new beds have been or are being added to our hospitals. Some of these have been built with the aid of Hill-Burton funds, but as many have been constructed and equipped with local capital raised totally through local effort.

For example, in our State capital, Indianapolis, we are presently in the process of raising \$12 million for the purpose of constructing new hospital facilities in a section of town now removed, because of traffic conditions, from easy access to present facilities, and for the expansion of existing hospital facilities to care for the rapidly growing population due to the steady expansion of industry in our community.

Cost of Medical Care

The next item which you were charged with surveying, namely, "The extent to which people are able to afford adequate medical care, with particular reference to present health insurance plans and their adequacy" really intrigues me. What I am about to say will probably be one of the most disputed statements made before your Commission. I make the statement that there is not a person who cannot afford to be sick. The constant attacks upon the medical profession for the high cost of sickness are unwarranted and without foundation.

In the first place, there has been no differentiation between the charges made by the physicians of this Nation and the many other factors of expense which are acquired through sickness, such as hospital care, drugs, appliances, etc. Taking only the physician's side of this picture, I repeat, the people of this Nation can all afford to be sick; even the percentage which we shall always have

with us who won't attempt to pay for their illness have adequate medical care available if the need is made known.

It is unfair to charge the medical profession with making the cost of sickness so expensive. Let us take the man working in industry. According to the Indiana Employment Security Division, in September 1940, the average weekly wage in our State was \$25.66 gross for an average of 65.9 cents per hour. At this time a laborer in the industrial area, known as the Calumet area of Indiana, was charged an average of \$150 for an appendectomy, \$100 for a hernia operation and \$2 for the treatment of a mashed toe or finger.

According to the same source, the average weekly wage in Indiana for this same group today is \$72.72, with an average hourly wage of \$1.723.

Today the same laborer will pay the same doctor an average of \$200 for an appendectomy, \$100 for a hernia and \$3 for a mashed toe or finger.

In 1940 it took 227.3 man hours of labor to pay for an appendectomy; today, he works 116 hours.

In 1940 he worked 151.5 hours to pay for his hernia operation; today, he works 58 hours.

In 1940 he worked 4.5 hours to pay for a mashed toe or finger; today, he works 1.7 hours.

Let us take a farmer, for example, and compare his cost of physicians' services a few years ago and today. In Indiana, we have a great habit of judging values on the prices of corn or hogs.

In 1940 the average going rate for an appendectomy was \$100, hogs sold in Indiana according to the United States Production and Marketing Administration, on September 14, 1940, for \$6.76 per hundredweight, and on September 13, 1952, for \$20.08 per hundredweight. Therefore, in 1940, it took 1,480 pounds of hogs to pay for an appendectomy. Today the average going rate for this same operation is \$160, yet it takes only 673.4 pounds of hogs to pay for this surgery.

In 1940 it took 160 bushels of corn to pay the \$100 charge, as again, according to the same authority, corn was selling for 0.63¢ per bushel on September 15, 1940. Today, with the operation costing \$150 and corn selling at \$1.57 per bushel, it takes less than 100 bushels to pay for the same operation.

Access to Health Insurance

I wish to qualify the above statements by stating that the charges for physicians' services are taken from a survey made in the highest-priced

areas of our State, and not in the lower-priced areas. In other words, if the comparison was taken from the rural areas of our State and the industrial comparison was made using our smaller industrial centers, we are certain there would have been even greater proof of the economy of medical care today as compared with a few years ago.

It is always amazing to us to hear some criticize the fact that present health insurance plans neither cover the entire cost of illness nor the total population of our great Nation. All cost of illness can be provided if the public is willing to pay the bill. Those who claim we need total coverage of all if we are to be a healthy Nation forget there are many other factors that go into providing health as we use the term—food, clothing and shelter, to name a few. Why, then, do we not also advocate prepayment plans for those necessities of life because, certainly, medical and hospital care are not the sole guarantors of health.

Approximately 25 percent of the population of Indiana is protected against the unexpected cost of illness by the Blue Cross and Blue Shield plans alone. This does not take into consideration the thousands protected by other insurance plans. Every person in Indiana has access to a plan of insuring against the cost of sickness, yet many refuse to take advantage of this opportunity.

Even the government has not encouraged its employees to take advantage of these plans. Through making payment of premiums possible by payroll deduction, industry has done that which the government itself has failed to do.

Health Program

The sixth purpose of your survey—to determine the adequacy of Federal, State, and local health programs, with emphasis upon the desirable level of such expenditure—is another question upon which all of us can place our own interpretation. It is our feeling that the greatest need today is a constructive educational program designed to encourage the public to consider more seriously their own health and that of their families.

In the field of preventive medicine the boards of health are doing an outstanding piece of work, if our experience in Indiana can be cited as a criteria. The boards of health, together with the many official and nonofficial agencies working in this field, are most cooperative, and all are active in attempting to encourage and conduct active

health programs in every community throughout the State.

The problem that appears the most difficult to solve is how to get people to take their health seriously in their everyday life, rather than become interested in health only when they arrive at the hospital or call a physician. People to a great sense do not seem interested in health, although there has been a marked increase in this regard during the past few years. This, I feel, is due largely to the effort being made by our many official and nonofficial agencies and their educational programs.

It is difficult to teach health to our school children, when, for example, they are not housed in a healthy environment. For example, on a recent tour of some of our schools hardly a washroom was found in which toilet paper, soap, hot and cold running water and towels were all in evidence; yet, we attempt to teach cleanliness as a basic item of health. Parents and others do not seem to be concerned with poor washroom facilities, yet how can we successfully teach health when the necessary items for practicing good health are not present? This is not meant in a tone of criticism, rather it is made a part of this record only to show the great problem we have in having people take an interest in the health of themselves and their children.

Measures to Encourage Health

For years, physical examinations have been advocated as a preventive measure against serious illness. Free X-ray examinations have been given to the public by one of our voluntary agencies; free diabetes tests have been offered by the profession, and a host of other services have been made available to the public in an effort to encourage it to develop better health practices. Our profession has offered speakers to groups to discuss health subjects and various diseases. Yet, in spite of all this effort, very few have taken advantage of these services in an effort to protect their health or to better understand the symptoms of disease.

The Indiana State Medical Association has 42 active committees, all of which concern themselves with some aspect of health. I would like to review for you just what we are doing in our program of assistance to the public in attempting to encourage better health practices.

Board of Appeals on Patient-Physician Relations. Established for use by the public in cases

in which they feel the physician has overcharged or failed to provide proper care.

Committee on Industrial Health. This committee prepared, published and distributed the first booklet containing instructions for nurses in industry. Requests have been received from throughout the United States and its possessions for copies. It has met with labor representatives, Government officials, management and physicians in an effort to encourage better health programs in industry.

Committee on Medical Education. This committee utilized, for the first time in medical history, the telephone to bring the latest in scientific medicine to our membership. Each month, by telephone circuit, our membership listen to an hour of discussion by outstanding authorities on new developments in medical science. We have, on occasion, had more than 6,000 miles of telephone lines leased for this program.

Committee on Publicity. Releases weekly a column on health to all the papers in our State.

Committee on Rural Health. This group is constantly meeting with representatives of rural people to discuss rural health measures. Each year they conduct a State-wide rural health conference which is attended by more than 700. In addition four regional meetings are held annually, at which time farm women are urged to attend. At these they attempt to show how to recognize symptoms of various diseases.

Chronic Illness. Indiana, we believe, is the only State at present which has a Joint Committee on Chronic Illness. The Governor of Indiana has seen fit to name the Chairman of the Indiana State Medical Association Committee as chairman of the Governor's Commission on Chronic Illness. A report will be filed with you on this subject.

Committee on Civil Defense. This committee has completed organization plans and has the medical phase of civil defense organized throughout the State and ready for immediate action. Locations for supplies and first aid stations as well as emergency hospital sites, transportation facilities, and routes have been established.

Committee on Maternal and Child Health. This committee works jointly with the Maternal Health Division of the Indiana State Board of Health. A detailed report of this activity will also be filed with you.

Committee on Legislation has worked hand in hand with the Indiana State Board of Health. We

are proud to say that we have supported and worked for the passage of all legislation deemed necessary by our Board of Health.

Committee on Medical Care Insurance. This group is constantly working with the insurance industry and continually studying medical care insurance in an endeavor to broaden these plans.

Committee on Medical and Nursing School Scholarships. Our Association, in an effort to assist needy young men and women to take up these professions, has been granting scholarships for physician and nurse training. In return for this, the graduates agree to practice in communities needing their services, for a period of years, to discharge their debt.

Committee on School Health and Physical Education. This committee conducts annual State-wide conferences for physicians, school administrators, teachers, nurses, etc. Today, in Indianapolis, such a conference is being held. These are followed annually with regional meetings throughout the State. Cooperating with us in this program is the Indiana Department of Public Instruction, Indiana State Board of Health, Indiana State Teachers Association, Indiana High School Athletic Association, Indiana School Board Members Association, City and County School Superintendents Association and the Indiana State Dental Association.

Committee on Crippled Children Services. This committee has cooperated with the official agencies in this field of endeavor. Through arrangements made with our physicians, the medical phase of caring for the crippled children is supplied at practically no cost to the taxpayers of our State. Our physicians are carrying on this work for a very small honorarium rather than on a fee basis.

Local Initiative Stressed

In conclusion, let me say that the medical profession of Indiana has been working hard in an effort to encourage people to recognize health, the benefits to be gained by all from good health practices. We are working closely with all groups which will permit us to work with them in an effort to improve continually the health standards of our people and our State. The facts stated herein, while not in as great detail as we would like the opportunity to present them, nevertheless give you some idea of what we are doing in Indiana.

We feel the greatest contribution the Government can make to the health needs of the Nation

is to encourage those who are working diligently in our voluntary health programs, rather than to discourage them through some of the insidious propaganda which has been released and which infers the efforts of millions of our people, interested in health, are of no avail. Why not begin a campaign of encouraging more local initiative, and more local voluntary effort. The people will do the job themselves with your encouragement rather than condemnation.

* * * *

Chairman KENNETH B. BABCOCK: Are there any questions? I would like to challenge you on your first statement that Indiana was just an average State. I have never heard any other Hoosier say that before.

Dr. WRIGHT: I am a Hoosier by adoption.

Medical School Support

Commissioner RUSSEL V. LEE: Dr. Wright, I would like to ask you a little about your medical school. It is a State institution, is it not?

Dr. WRIGHT: That is right.

Commissioner LEE: You have no private medical schools?

Dr. WRIGHT: Just the one school.

Commissioner LEE: Do you think the State should pay the cost of maintenance of that or that the medical student should pay his own freight?

Dr. WRIGHT: It is part of the State institution and I think the State should pay it.

Commissioner LEE: All of it?

Dr. WRIGHT: Yes, I think all of it.

Commissioner LEE: You think the tuition should be free?

Dr. WRIGHT: The tuition now is not free. There is a charge for tuition but it is a very small amount.

Commissioner LEE. Not enough to cover the cost?

Dr. WRIGHT. No.

Commissioner LEE. What do you think should be done about the private medical schools, all of which are in trouble right now? Should the States bail them out, too?

Dr. WRIGHT. As you know, the American Medical Association—you are familiar with their program—I am not qualified to say what should be done there actually. I have not made a—

Commissioner LEE. It is a problem in our lap at the moment because the deficit I think is going to be over \$30 million this year, and the AMA may find it is not going to be nearly enough.

Dr. WRIGHT. My feeling is that should be left up to private enterprise.

Commissioner LEE. In Pennsylvania the State subsidizes all private schools in Pennsylvania the same as the State schools in your State.

Dr. WRIGHT. I think there may be some points for and against it. I am not familiar enough with it to discuss it intelligently.

Commissioner LEE. You are perfectly willing in Indiana, though, for the taxpayers to support the medical school like they do the rest?

Dr. WRIGHT. Yes.

Commissioner LEE. Are you willing to have that extended to nurses, lab technicians, and other associate medical personnel?

Dr. WRIGHT. I think that should be limited.

Commissioner LEE. We have the shortage of paramedical personnel that seems worse than doctors.

Dr. WRIGHT. Yes. That is true because more technicians are being utilized.

Statement¹ of

DR. JOSEPH POST

President

Philadelphia County Medical Society Philadelphia, Pa.

I am President of the Philadelphia County Medical Society which was founded in 1849 and represents over 3,200 practicing physicians. The Society is a component of the Medical Society of the State of Pennsylvania as well as the American Medical Association. Our chief functions are to raise professional standards, maintain the ethical practice of medicine, and to endeavor to make available to everybody a high quality of medical care irrespective of ability to pay for it.

I will attempt to touch on all of the health problems under consideration by the President's Commission on the Health Needs of the Nation, as they apply locally, and will emphasize in particular those matters with which we are more directly concerned.

Health Personnel

Current shortage of health personnel: There are approximately 4,000 practicing physicians in Philadelphia. We believe this number to be en-

tirely adequate for the needs of the city's population of two million persons.

The services of many of these physicians are used regularly by persons living in suburban Philadelphia as well as the more remote parts of Pennsylvania, New Jersey, and Delaware. Even allowing for the concentration of specialists in central Philadelphia there is a satisfactory distribution of physicians in all areas of the city. With modern means of rapid transportation, less reliance has to be placed on the necessity for a physician to practice in close proximity to his patients.

It is important, however, to distinguish between a "shortage" and "poor distribution" of physicians in considering the over-all situation throughout the country. We do not need more physicians in the United States but there should be a wider distribution in certain rural areas to meet the needs of the population. In urban areas like Philadelphia this situation does not exist.

In order to meet local emergency medical situations the society in the early part of 1950 established its Emergency Medical Service program which is operated through a special telephone exchange. This service has been functioning well and handles approximately 2,000 calls annually. We believe it is serving a definite community need.

Adequacy of Local Public Health Units

As a first class city Philadelphia naturally maintains complete public health facilities to meet the needs of its population. . . . The society has always worked closely with the local department of health and . . . acted in an advisory capacity to the department particularly in the fields of child health, tuberculosis, diabetes, maternal welfare, communicable diseases, and venereal disease control.

Medical Research

Philadelphia as a medical center would be expected to have extensive medical research facilities. With 5 undergraduate class A medical schools, an outstanding graduate school of medicine, and 49 approved general and specialized hospitals, a great deal of current medical research is being carried on in all fields of medicine.

* * * * *

However, in spite of this apparent satisfactory situation, our medical research efforts have been greatly hampered by difficulty in securing sufficient animals. This problem has arisen from the determined opposition of the antivivisectionists to

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

the passage by the General Assembly of legislation which would make available to accredited research groups animals now being put to death in the public pounds.

* * * *

Hospitals and Clinics

A great medical center such as Philadelphia would be expected to have available adequate hospital and clinical facilities to meet local needs. Our 49 approved hospitals have almost 20,000 beds, and additional facilities are now under way in many of these institutions to meet growing demands. Most of our general hospitals offer complete clinic facilities to those unable to afford private medical care. Our position as a teaching center enables us to bring to the public the latest knowledge of the diagnosis and treatment of disease, and in this respect our facilities are unexcelled in any other part of the country.

Our local hospitals not only care for general medical needs but special hospital facilities are also available for tuberculosis, cardiac, eye, pediatric and mental disorders.

Problem of Additional Hospital Beds

However, one of our most acute problems is the need for additional beds for a large waiting list of acute tuberculosis cases. Through the efforts of the Philadelphia County Medical Society and the Philadelphia Tuberculosis and Health Association, public interest in this problem was aroused several years ago. As a result the city arranged for the hospitalization of many of these cases in general voluntary hospitals. In addition * * * it is hoped that in the very near future 600 additional beds will be made available for such treatment. The existence of this large waiting list created a serious public health problem and its immediate solution is imperative.

There is a local need for institutions for the custodial care of chronic cases, especially in the field of senility and terminal cancer. The Philadelphia General Hospital at present has many patients in the former category and their transfer to a separate institution would provide beds for more acute cases of illness which are amenable to treatment.

A number of local voluntary health agencies, together with the Department of Health and the Philadelphia County Medical Society, are studying these problems, and it is to be hoped that an early solution may be reached.

It is our earnest belief that these and other health needs can and should be solved on a local level. Assistance from the State or Federal Governments should be sought only after all local means have been exhausted.

Medical Care

It is somewhat difficult to define clearly the term "adequate medical care," since it involves a large number of variable factors, including the necessity for the individual to appreciate good health and to assume some personal responsibility to keep well. It is essential that the public should become fully familiar with the availability of medical care in the community and know how to utilize it. Many charges of so-called inadequate medical care in various communities have been found to be baseless and arose from the indifference or unwillingness of certain individuals to seek medical care where available. This whole subject is a problem of lay health education and is the responsibility of all groups interested in good community health.

It can be said without fear of contradiction that adequate medical care, as the term is generally understood, exists in Philadelphia. The ward and clinic facilities of our hospitals are more than adequate to provide for those unable to afford private care. In addition, the Department of Public Assistance has a comprehensive medical care program for those on relief. It should not be overlooked that physicians in private practice, both in their offices and in hospitals, are daily caring for the sick irrespective of ability to pay. It has always been the aim of the medical profession to make its services available to anyone in need without any primary thought of remuneration.

Long-Term Illness

The problem of long-term illness is one of a serious economic and social nature. This fact is widely recognized by medical, social, governmental and other groups. However, it is not a problem of great magnitude in terms of involving a large segment of our population. Some plan must be devised to assist those persons affected by this catastrophe, and it is certain that the insurance industry, with its background of experience, will offer a practical solution in the future. In fact, experimental catastrophic insurance plans now in operation offer very optimistic possibilities.

The medical care of the medically indigent is the primary responsibility of the government.

However, inadequate funds are being provided at present by the State to cover the cost of hospital care of this lower income group. This is a serious situation and is one of the factors causing hospital deficits.

The medical profession, through the American Medical Education Foundation, is endeavoring to demonstrate the role which private enterprise can assume in meeting existing deficits in medical schools. It is anticipated that through such leadership other persons and groups will realize an equal responsibility to meet the financial problems of both our hospitals and medical schools. The assumption of such obligations by the Federal government merely removed from the local community, through taxation, funds which should be permitted to remain there for local use and control.

Health Programs

In considering this subject too much emphasis cannot be placed on the importance of local health programs. Certainly urban centers, like Philadelphia, would seem to possess sufficient means to meet most of their health needs. However, this involves full recognition by the officials of local government and the public of the necessity for complete local responsibility in solving our health needs. The extent to which this obligation is transferred outside of the community results in local apathy, remote bureaucratic control, and lower quality of service.

The present high quality of medical care, its wide distribution, and lowest economic burden can be best maintained by emphasis on local health programs and maintenance of the private practice of medicine. The direct physician-patient relationship is important in furnishing to the public the highest quality of medical care.

Local communities should be constantly encouraged by Federal and State authorities to face their own problems. This is not easy to achieve in view of the present trend toward and availability of Federal subsidies. However, no general national pattern can be established for meeting local health problems, since they can best be handled by local authorities best acquainted with them, working with an enlightened public.

* * * * *

Distribution Problem

Commissioner Albert J. Hayes: Dr. Post, before you leave the microphone I wonder if you

would care to express very briefly your own views to the Commission as to the best solution of the problem of poor distribution.

Dr. Post: The poor distribution—well, I think there are several things which I would like to touch on and which time would not permit me to touch on. I think one of the situations which cannot be helped at the present time is the fact that a very fair percentage of our personnel are being taken into the Armed Services and that naturally brings down the number and also the distribution. I think if some method might be provided whereby young men starting out in the practice of medicine, as I did some 43 years ago, not only be encouraged but almost forced to stay in general practice for at least a period of 5 years, I think that would help and go a long way toward the problem of the number as well as the distribution of physicians.

Then, again, I think this question of distribution is something which has been terribly overrated at the present time. With good roads and, as touched on in this paper, automobile traffic, there are very few people who cannot reach or be reached by a physician in the regular course of his professional activities. Of course, when we get down into some of the real rural districts, there, I think, that the problem is to try to make it worth while for the younger men to go there and stay for a time. I think after you once got them—if I had time I could give several illustrations—

Commissioner Hayes: If I may interrupt—what we are particularly concerned about is what do we need to make it worth while?

Dr. Post: I do not know.

That is beyond my individual answer.

Commissioner Hayes: I know the Commission is interested because we have volumes of testimony from experts all over the United States which, without question, shows that in the rural and remote areas of the country there is definitely a shortage of all types of doctors.

Dr. Post: Well, with all due respect I do not think that that question can be answered any more satisfactorily than had you asked me why people go and live in these rural districts where physicians are not. I know I have not answered your question but I cannot do it.

Commissioner Hayes: Thank you very much, Dr. Post. We appreciate your testimony.

Statement¹ of

V. O. FOSTER

**Executive Secretary
Tennessee Medical Association
Nashville, Tenn.**

The six stated major health problems will be discussed as they apply to Tennessee.

Health Personnel

One, current shortages in health personnel:

Doctors: According to the American Medical Directory, 1950, there were 193,205 physicians in the United States (excluding those in government service), or 1.28 per 1,000 population. In Tennessee, there were 3,113 physicians, or 0.94 per 1,000 population. The deficiency exists in the rural areas.

Dentists: In 1951 there were 1,008 dentists in Tennessee, or 0.30 per 1,000 population. It is believed that at least twice this number is needed. Again, rural areas show greatest need.

Nurses: In 1949 there were 3,720 professional nurses in active practice in Tennessee. Needs for the same year were estimated at 6,026. The present ratio is 1.1 per 1,000 population. Admissions to nursing schools have not increased.

Shortages in health personnel in Tennessee are being ameliorated. Our three medical schools are now on the quarter system, i. e., operating on a year-round basis. The number of students admitted to these schools is consistently increasing. Undoubtedly the Commission is aware of the fact that the increase in our physician population during the last decade exceeded the percentage increase of the population as a whole. As to nurses, in Tennessee an intensive nurse recruitment drive has been launched; a 2-year training program for nurses is projected, and practical nurses are now licensed as such by the State of Tennessee.

Public Health Units

Second, the adequacy of local public health units:

Local public health units now service 95.5 percent of the population of the State. Only 11 small counties are not included. Only 79.3 percent of the population, however, live in counties with full-time health officers. Public health department staffs are insufficient due to lack of well-trained personnel and adequate financial support.

Since the number of public health officers has more than doubled in Tennessee in the last few years, it appears that the remaining counties without public health services will be cared for ultimately.

Research

Third, the present status and adequacy of medical research.

More than \$181 million is spent annually on medical research in the United States. Medical research in Tennessee is concentrated in Nashville and Memphis, the locations of our three medical schools.

Grants in aid now in progress at Vanderbilt School of Medicine total \$232,610.74. Current funds for research at Thayer Hospital (VA), Nashville, total more than \$100,000. Current research grants at the University of Tennessee Medical School total \$396,134.20. Exact figures for Meharry Medical School were not available, but are estimated at \$100,000. These figures do not, of course, reflect the total investment in medical research. They do not take into account the direct and indirect costs incurred by the grantee institution.

Medical research in Tennessee is rather well supported. The limitations on research are physical space and technical assistants, rather than funds.

While funds for medical research in Tennessee are deemed adequate, the expenditure of money alone is not a reliable yardstick of either the quality or the quantity of pure research. Probably research into the problems related to public health activities, long-term epidemiological studies, chronic illnesses, and the diseases of old age, is suffering because of the emphasis upon immediate and highly pinpointed areas of investigation.

From a philosophic standpoint, however, medical research will never be adequate as long as scientific questions relevant to medicine remain unanswered.

Hospitals

Fourth, the degree to which hospitals and clinics meet existing needs.

There are 3.0 acceptable general hospital beds per 1,000 population in the United States. In 1950 there were 2.5 beds per 1,000 population in Tennessee. According to an estimate by the re-

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

vised hospital and construction plan (Hill-Burton program), 59 percent more beds, 5,469 are needed.

The shortage of hospital beds in Tennessee is being relieved by private construction and through the Hill-Burton program. As of July 1, 1952, 25 Hill-Burton construction projects had been completed and were in operation at a total cost of \$191½ million. 1,370 additional beds were supplied. An additional 15 projects were under construction at a cost of \$25 million to supply an additional 861 beds.

Fifth, the extent to which people are able to afford adequate medical care.

Medical Indigency: A recent study of indigent hospitalization showed that 67 general hospitals in Tennessee incur an annual deficit of \$1,600,000 for indigency care. Of all patients admitted to these hospitals, 22.1 percent were classified as indigent and 4.3 percent others were unable to pay their bills. It is our opinion that no more than 25 percent of the population of Tennessee could be classified as medically indigent under any acceptable definition.

Health Insurance

At the end of 1951, 85,991,000 persons in the United States had hospital expense insurance; 65,555,000 had surgical expense protection and 27,723,000 had medical insurance. Of the 3,291,718 people in Tennessee, 1,257,000 owned hospital coverage, 848,000 had surgical insurance, and 172,000 were insured against medical care. Of the 848,000 holding surgical insurance, 400,000 are insured under the 3-year-old Tennessee Plan, a program of prepaid surgical insurance sponsored by the Tennessee State Medical Association.

The rapid growth of voluntary health protection is indicated by the fact that hospital insurance has increased by 12 percent in 1951 over 1950; surgical expense coverage increased 20 percent and medical expense coverage increased 28 percent for the same period. The rate of growth of voluntary health insurance in Tennessee has kept pace with the national average.

The Tennessee State Medical Association secured the establishment of a Commission on Indigent Hospitalization which will make its report and recommendations to the Governor on October 1, 1952, with the hope that a method of financing the cost of hospitalization for the medically indigent can be worked out, whereby no person in Tennessee will be denied necessary hospital care

by reason of inability to pay. With or without this program for indigent hospitalization, physicians' services to the patient will continue on the time-honored basis of service to the patient irrespective of his ability to pay.

The Association, through the Tennessee Plan has developed a sound and economical method whereby working people can purchase medical care through prepaid insurance. We firmly believe that a sound program of indigency care at public expense and prepaid insurance, when held by a majority of the population, will leave no major problem in the financing of the cost of medical care.

Health Programs

Sixth, the adequacy of local, State and public health programs:

According to recent reports, Tennessee had the lowest per capita annual expenditure for health activities of all official agencies.

The per capita expenditure by the health department in Tennessee was \$1.16, which was approximately the same as in the United States in 1950. This amount is not considered sufficient, and it is believed that adequate health services would require at least \$3 per capita.

For inclusion in the official record, there is attached to this statement a report of the University of Tennessee regarding medical research in the field of radioactive isotopes, to be conducted in a new general hospital at Knoxville, Tennessee. This information was not available in time to be incorporated herein.

Statement¹ of

DR. R. D. BERNARD

General Manager

Iowa State Medical Society

Des Moines, Iowa

With one or two exceptions, the State of Iowa has an adequate supply of physicians. The American Medical Association, after thorough investigation, has found that one physician can serve 1,500 people. That is the figure which was used during World War II to determine the essentiality of physicians. In Iowa we have one physician for every 995 persons.

¹ Delivered at the Regional Hearing, Minneapolis, Minn., September 2, 1952.

Modern, hard-surfaced roads, vastly increased telephone facilities, and modern hospital facilities, are within a few minutes of any citizen in the State.

Iowa has 99 counties. Within the past two or three years the Iowa State Medical Society has cooperated in placing 175 physicians in small rural communities. It is at present cooperating with the Armed Forces in locating physicians who are being separated from service. Through this cooperation it is hoped we may place a physician in every community where another doctor is called into service.

The Iowa State Medical Society cooperated with the Iowa legislature to obtain additional funds to increase the size of the freshman medical class from 90 to 120. A report of June 1952, shows a 50 percent gain in enrollment at the College of Medicine since the school year of 1947-1948. This undoubtedly will result in an increased number of physicians being graduated.

Assisting the Medical Student

The State Medical Society, in cooperation with the College of Medicine, has sponsored a preceptor program in which all junior medical students will work with a general practitioner during the summer months. This will familiarize them with general practice, and it is hoped it will encourage more physicians to enter this area.

The State Medical Society has an official loan fund to help senior medical students, and members of the medical profession are even now setting up another large loan fund for medical students, one condition of which will be that the student agrees to enter general practice in the State for five years after internship.

Specialty training is available at the University hospitals and at several of the other large hospitals. The State as a whole is well served by the various specialties.

Medical Care Record

Certain figures give evidence of the type of medical care being provided within the State. Iowa has the lowest percentage of tuberculosis in the country; it has one of the best records in maternal and infant mortality, in venereal diseases; and, finally, its longevity record is one of the highest in the Nation. It is interesting to note that 96 percent of all babies in Iowa are born in hospitals.

Maternal death rates have dropped from about

59 to less than 6 per 10,000 live births; tuberculosis deaths have dropped 75 percent in twenty years; infant deaths have been reduced from 53.9 to 24.5 per 1,000; and pneumonia and influenza death rates have dropped two-thirds in 20 years.

These things have been accomplished through the cooperation of the medical profession and the State Department of Health under the leadership of Dr. Walter L. Bierring.

Public Health

We believe this is being well handled in Iowa. The Extension Service of Iowa State College, the State Department of Health, and the Iowa State Medical Society are working together to establish local health councils. Thirty-three are now in existence. Iowa has six regional health services and three county health units. We have 52 trained public health nurses.

We feel, as do the other organizations cooperating with us, that the local community should accept its responsibility in health matters. A more satisfactory service can then be rendered more efficiently and economically.

The present status and adequacy of Medical Research: Funds for medical research are centered at the College of Medicine. The faculty tells us it has sufficient funds for research, but lacks a building. During the next session the legislature will be petitioned for funds for such a building.

Hospitals and Clinics

The degree to which hospitals and clinics meet existing needs. In our opinion, Iowa has a very adequate supply of hospitals. Utilization for the year ending July 1, 1952, showed only 67.7 percent of capacity. In some instances the distribution of patients has been unequal, due to unusual circumstances, just as hotel beds may be short during a convention, yet adequate for the normal trade.

Most of the small community hospitals have arranged for a consulting service of qualified pathologists, radiologists, surgeons, and other specialists. This gives the people of the smaller communities access to specialized medical care. Iowa has several centers where every type of medical care is available and many others where all but the most specialized care may be obtained. Geographic distribution is excellent.

Mental Health Clinics

The State does need more mental health clinics. The Iowa legislature has been appropriating from

one-half to a million dollars per year to establish screening centers in the State mental institutions. The Iowa State Medical Society believes that equal emphasis must be given to the establishment of local mental health clinics. This problem needs a great deal of work, and we have had a special committee working upon this for over a year. Apparently some progress is being made.

Health Insurance

The extent to which people are able to afford adequate medical care, with particular reference to present health insurance plans and their adequacy:

Let me first mention the public programs in Iowa. Since 1933 each of the 97 medical societies in the State has had a contract with the boards of supervisors providing for the care of indigent and medically indigent persons. This is one way medical care is given to those of meager circumstances.

In addition, many counties have a committee which will, when asked to do so, review fees charged and scale them to the income of the patient.

Every doctor participates in and supports local projects for community health.

Second is sickness insurance. Iowa has a population of approximately 2,600,000 persons. Of these, 1,309,000 have hospital insurance, of which over half is Blue Cross; the balance being commercial companies.

1,045,000 have medical and surgical insurance to take care of physicians' services, of which approximately 50 percent is Blue Shield.

The growth of Iowa Blue Cross and Blue Shield has been phenomenal. Blue Cross has been in existence eleven years, and the Blue Shield about seven. I would say these two organizations cover 25 or 28 percent of our population.

Commercial companies have entered this field only in the last few years. At present, hospital and medical insurance exceeds the usual percent of all types of insurance coverage, such as fire, automobile, et cetera.

Policies covering catastrophic illness are available at moderate cost in Iowa. Blue Shield has been studying the possibility of increasing its coverage in this direction.

The adequacy of Federal, State, and local health programs, with emphasis upon the desirable level of such expenditures:

Inasmuch as Dr. Walter Bierring is without doubt the most qualified individual in the State to discuss this question and since he will speak later on the program, we will withhold comment, except to say that local and State health funds have increased 200 percent in the last ten years.

The State Department of Social Welfare is turning the medical program of the OASI back to the counties where experience has proved it can be handled more efficiently.

In conclusion, Iowa can and is meeting its problems. We have stated the positive programs being carried on, realizing that many problems still exist and that in the field of health we must still carry forward. It is our firm belief that in Iowa progress in the health field is being made as rapidly as it is in agriculture or industry.

Statement¹ of

DR. R. G. ARVESON

Chairman of the Council

The State Medical Society of Wisconsin

I am Dr. R. G. Arveson, of Frederic, Wis. I appear before this hearing as a practicing physician and represent Wisconsin doctors and their organization, the State Medical Society. I am Chairman of its Council, a past president, and have served on many of the Society's committees, including one established in the late 1930's to conduct hearings throughout the state as to the health needs and problems of the citizens of Wisconsin.

* * * * *

There are many organizations having general or specialized interests in the health of the people, but none having a more comprehensive knowledge of health facts, nor a more genuine interest than organizations of general practitioners and specialists representing all physicians of America.

In Wisconsin, voluntary health insurance—in the few years since such coverage became available—protects approximately half of its citizens. Were it not for the carping criticism of various propaganda sources—including the unceasing demands of elements within the Federal Security Agency for compulsory health insurance, with the resulting effect of discrediting the voluntary plans—voluntary insurance would be much more extensive in Wisconsin today, as well as in the nation.

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

All items expressed in today's agenda are relative terms.

If we are to judge adequacy of research, of insurance, of public health units, and of the ability of people to purchase protection in light of the needs of a decade ago, this Nation—and my state with it—is moving so rapidly toward a millenium that the physicians of Wisconsin feel inspired and elated.

One must measure the future by the progress made in the past.

Observe the tremendous developments in the field of antibiotics. Note the continued advances in preventive medicine. Consider the marked progress made in reducing total periods of hospitalization to a point that while costs have been increased in direct proportion to the inflationary trends, the cost to the individual is lessened by his shorter period of stay.

In light of such progress, no question can remain in the mind of a reasonable man, sitting in impartial judgment, that this Nation is just as rich in its health achievements as it is rich in its economy, its manpower, and the availability to the average citizen of all the daily needs and many of the happy luxuries of life.

In public health, for example, it has not been necessary for Wisconsin's State health officer, at any time in recent history, to make a statement similar to that attributed to Dr. Leonard A. Scheele, Surgeon General of the United States Public Health Service. The Washington Post of December 5, 1949, reports him as saying that the seat of the Federal government, the City of Washington, D. C., "is one of the few cities in which backyard privies and outdoor water hydrants are a major health hazard . . . affecting upward of one hundred thousand people" and constituting the greatest single environmental hazard to health in the District.

Public Health in Wisconsin

Public health in Wisconsin stands at the highest peak in its history. The capabilities of the State Board of Health, and its administrative personnel, in full cooperation with the voluntary and unregimented efforts of the practicing physician, the nurse, the engineer, the dentist, and others, assure still further achievements in that field.

In the City of Madison is the famed University of Wisconsin, noted for its traditional pursuit of all fields of knowledge and the dissemination of its findings beyond the borders of its campus.

In that University exists a great medical school, dedicated to the training of the doctors of the future. It is a taxpayers' institution and exists by reason of the effort of the citizens of Wisconsin.

In Milwaukee there is another fine institution—the product of cooperative, nonprofit, and religious energy—a voluntary institution including the Marquette University School of Medicine.

In these two institutions total research grants approximate \$300,000 annually. In the last two years the Wisconsin Division of the American Cancer Society collected more than \$400,000 in voluntary contributions from Wisconsin citizens. Research—in Wisconsin—continually moves forward.

Medical Society Service

I call your attention to the forward-looking program of the State Medical Society in providing open panels of physicians under the Workmen's Compensation Act, its physician placement service, its effective public health education work, its many efforts in the field of scientific medicine, and the continuing distribution of the latest scientific knowledge by holding postgraduate training centers throughout the State.

I have only two minutes left, so the gentleman says, but I think that others had a little more time, but I am going to tell you this:

This constitutes but a portion of its activities, which anticipate the future needs of the citizens of Wisconsin, and provide sound solutions for them.

An example is the realization in Wisconsin of the trend toward an older population and of the ultimate necessity of homes in which the aged may receive care and comfort during their declining years.

Legislation

In 1951, anticipating this need, and providing a mechanism for it, legislation was devised by the Medical Society, with the assistance of other groups such as county judges, and passed by the Wisconsin legislature.

I will say this: that in my judgment the real point is to look at the American citizen himself.

He is ambitious; he is successful; he is proud of his Nation. He glories in its tradition and he is confident of its future, because he is a part of that Nation, free and unregimented, encouraged to seek through the traditional ways of voluntary efforts further improvements in his social status, his personal needs, and his daily way of life.

The physicians of Wisconsin will use their utmost energy to protect and relieve the farmer, the laborer, the white-collar worker, and others within the moderate or lower income groups from being taxed to support government health programs in fields which are now adequately being developed and served by voluntary efforts.

There can be no freedom of choice or initiative where unnecessary taxes are the added burden which virtually exhausts a man's resources.

I find myself in fundamental disagreement with those who would substitute the police power of the Federal government for the initiative of the individual.

This point deserves emphasis for it is the most basic decision facing the country today.

Commission Criticized

It is my belief that this Commission, which cannot function beyond December 29th, obviously cannot complete its responsibilities of making a searching inquiry even as to the State of Wisconsin.

I believe that the circumstances of this particular hearing should be directed to the attention of the two principal candidates for the Presidency, so that they may have an opportunity to express their own views as to the fundamental problem I have raised in my statement.

I am, therefore, at this time, directing the following telegram to Dwight D. Eisenhower and Adlai Stevenson:

Today I appeared representing the physicians of the State of Wisconsin at a one-day hearing of the President's Commission on the Health Needs of the Nation held at Minneapolis. Notification that the State Medical Society of Wisconsin was to have opportunity to appear was directed to our executive office only eight working days preceding the date of the hearing. Many organizations received similar invitations, as apparently did individuals. We were told to limit oral presentations to ten minutes. My statement before that hearing follows in full, and this identical telegram is sent each of the two major presidential candidates. I have grave doubts that this Commission can fulfill the objectives stated by the President in his Executive Order creating it. If it conducts its proceedings as illustrated by this hearing, I doubt that it can receive anything more than statements based upon emotionalism, impressions, and prejudices, either without foundation in fact, or based upon inadequate information. I know the physicians of Wisconsin would welcome any genuine "searching inquiry" and "critical study" of the health requirements in our state, but such an inquiry and such a study for Wisconsin alone obviously calls for adequate advance

planning of sufficient competence, and hearings of sufficient duration, to assure that the Commission can meet the President's charge. I believe the physicians of this country and of Wisconsin in particular are entitled to a statement from you relative to your intents as to the future of the Commission, if you are elected the Nation's President.

This telegram will be signed by R. G. Arveson, M. D., Chairman of the Council, State Medical Society of Wisconsin, Madison, Wisconsin.

* * * * *

Commissioner MARION W. SHEAHAN: You know, you can always find quite a few points of agreement, even though on the surface there appears to be disagreement. I am very certain that there is not a member of the Commission who does not have the same feeling the doctor has—but not exactly for the same reasons.

I think I may say for the Commissioners—not at all in defense of them, but in explanation—that obviously the job is a very large one. But if the Commission is sensible enough to delimit the areas that it thinks it can consider, there is a wealth of information that is already available, and sometimes we chase bugaboos when we keep on saying we need longer and longer periods to study what has already been studied over long, long periods before. That, I think, is the premise upon which the Commission is proceeding—that we are not going into the unknown, but we are going to try to sort out what is known, and to draw as logical and rational conclusions as can be produced by a great amount of pooled judgment. And I think possibly my fellow Commissioner might support me in that, so that we entirely agree with Dr. Arveson, even though, let us say, we disagree, which is a very nice and friendly way to start.

Statement¹ of

DR. A. L. ALESEN

President

**California Medical Association
San Francisco, Calif.**

Great stress is currently laid upon medical economics. It is contended that the cost of good medical care is so great that large segments of our people are unable to afford it, and therefore are deprived of their rightful opportunity to good health and well-being. . . .

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

It has always been one of the prideful goals and traditions of American medicine to place within the reach of every individual in this country the best grade of medical care at a price that individual can afford to pay, whether that be a high fee, a low fee, or no fee at all. That this goal has in large measure been achieved is attested by the fact that the American people are the healthiest people in the world today, bar none, when comparable populations are considered.

Further, under our system of the private and competitive practice of medicine as an integral part of the American system of profit and loss, we have made strides in our profession comparable to the marked developments in industry and business, and for exactly the same reasons.

Economics is defined as the science of the production, the distribution and the consumption of goods and services; or a study of the way man makes his living. The ideal state of economic health would be an economy in which there are readily available the greatest amount and variety of goods and services to every individual living within the economy, at a price well within his reach and in an environment in which he finds encouragement to produce to his utmost, to consume, to distribute, and to accumulate the products of his labor.

The fact that during the six thousand years of recorded history there have been a few instances in which the definition of the ideal economy has been met is significant. The fact that these instances have been short-lived and the reasons for their termination have particular importance for this discussion.

History teaches one outstanding and never-failing lesson: social and economic structures have been productive, strong, and expanding when group or government action has been limited to its appropriate biologic function—that of protection of the individual in the enjoyment and accumulation of the fruits of his labor. Under such social and economic organizations, individual responsibility has been paramount: individual reward for individual merit; individual penalty for individual failure has been recognized as inviolable.

However, in practically all of the human societies, sooner or later, the collectivist has insinuated his siren song of group action and immediately thereupon the process of disintegration and decay has commenced. Historians tell us that

there have been approximately 2,500 instances of the communistic or collectivistic state in the world's history without a single instance of success, unless one wishes so to designate our great sister democracy, Russia.

America's Productiveness

Over the past fifty years in America, because of the application of tools and the use of constantly improving techniques, our productivity has increased on the average of about 3% per year. By and large, that increased productivity has over the years been well distributed. A few examples will show how well.

In Russia, under Communism, the workman may buy one-third quart of milk with his hour's labor. In England, under Socialism, he can buy three quarts. In America, under private enterprise, his hour's labor will buy him six quarts of milk. In Russia, under Communism, the individual has available forty square feet of housing. In England, under Socialism, he has one hundred and five square feet. In America, under individual enterprise, he has four hundred and ten square feet of housing.

In Russia there is three-quarters of one telephone per 100 persons. In Great Britain there are eight telephones. In America there are 22 telephones per hundred persons. In Russia the workman can buy one-half pair of shoes for one week's work. The American workman can buy six pairs of shoes. The Russian workman can buy one-half suit of clothes for one month's work. The American workman can buy four suits of clothes.

In the United States there are approximately eighty million life insurance and annuity policy holders with a total of approximately two hundred and fifty billion dollars of such protection, all developed under our competitive system. Over seventy million Americans have bank accounts.

With six percent of the world's population, Americans enjoy 94 percent of the television sets, 92 percent of all bathtubs, 85 percent of all automobiles, 54 percent of all telephones, 48 percent of all radios. Our six percent of the world's people consume 65 percent of the world production of corn, 60 percent of petroleum, 60 percent of wheat, 53 percent of wool, 47 percent of coffee, and 45 percent of meat.

The American Federation of Labor compiled a report on comparative real wages just before

World War II. This report stated that in America the workman's hour's work would buy him 3.8 market baskets of groceries; in Denmark 2.18; in Great Britain 1.8; and in Italy, 0.96.

A proper question is as to whether or not the laboring man has in fact benefited by this increased productivity. This question is answered by figures recently released by Mr. Joe Hertel, Farm Advisor, University of California College of Agriculture and United States Department of Agriculture, San Bernardino, which speak eloquently on this subject:

"In 1929, the average wage earner in the United States received 56 cents per hour. In 1951 he received \$1.60 per hour. In 1929 he had to work 47 minutes to buy a pound of round steak which required 41 minutes in 1951. He works 29 minutes now to buy a pound of pork chops for which he labored 39 minutes; nine minutes to buy one quart of milk as compared to 15 minutes; 21 minutes to buy one pound of poultry meat in 1951 compared to 41 minutes in 1929; and, only 25 minutes to buy a dozen eggs for which he labored 54 minutes in 1929; and he gets one pound of turkey for 22 minutes of work as compared to 55 minutes in 1929."

Just how much more might have been accomplished had we not during this period of time been impeded in our economic progress by all manner of government interferences as well as by the strictures interposed by sit-down strikes, feather-bedding tactics, and sabotage.

Economic Benefits

Turning now to the application of fundamental economic principles to the problem of good medical care, it would first seem pertinent to determine just what portion of the American family budget is actually required for good medical care, and whether or not the average family is in fact being deprived of good care because of high cost.

In the year 1950, the American people spent eight billion dollars for all types of medical care, this representing 4.4 percent of the \$193,600,000,000 that they spent for all goods and services in that year. Over the years, the outlay for medical care has varied from 4.1 percent to 4.4 percent as noted in 1950.

In 1950, the American people spent 5.8 percent for recreation, such as football, baseball, and other spectator amusements, theatre admissions, bowling, horseracing. They spent 4.2 percent for alco-

holic beverages or only a trifle less than for all types of medical care. They spent 2.3 percent of their budget on tobacco; 1.2 percent on barber-shops, beauty parlors, baths, m^assages, toilet articles and cosmetics; and 0.8 percent on jewelry, clocks, watches, and their repairs. Thus, it would seem that, mathematically at least, the expenditure of three times as much for alcohol, recreation, and tobacco as for medical care, would not justify the contention that medical care is out of the reach of the average citizen.

Medicine's Loaf

During the twenty years between 1930 and 1950, some variation occurred in the way our people spent their medical dollar. In 1930, the physician got 32 cents of it, now he receives 28 cents of it, an actual decrease of 12 percent. In 1930, dentists got 16 cents out of the dollar, now they get 12 cents, or 26 percent less. In 1930, 19 cents of the consumer's medical dollar went for drugs, in 1950 only 17 cents, a drop of 12 percent. Fourteen cents of the consumer's dollar in 1930 went to the hospitals whereas in 1950, 23 cents was so consumed, or an increase of 66 percent. This is a marked increase, but there are certain offsets and explanations of these figures which make hospital care not so high relatively as it would appear at first glance.

The cost of all goods and services purchased by consumers rose 72 percent between 1930 and 1950. On the same scale, hospital rates increased 135 percent, but physicians' fees were up only 40 percent, and surgeons' and specialists' charges up only 41 percent.

During that same base period, the average weekly earnings of production workers in manufacturing industries rose 165 percent.

Translating these facts into terms of real wages, that is the purchasing power of the consumers' services in terms of medical and hospital services, some rapidly lowering death rates and decreased morbidity in all of the major conditions, with the exception of the degenerative diseases, shows that the American people are in fact taking advantage of the increased techniques and have in fact not been barred by any alleged economic obstacle.

Voluntary Prepayment Coverage

With more specific reference to your four questions, it is our belief in response to question number one, that there are no major unmet health needs in this area. The State Chamber of Commerce is

at this time conducting a survey to ascertain the extent to which the people of this State are covered by voluntary prepayment plans for the cost of medical care. It is our opinion that at least six million of the State's 11 million are so covered in some manner. Our own Blue Shield and Blue Cross plans, together with the many excellent indemnity plans written by the private insurance companies, have made and are making rapid strides toward removing the economic shock from illness. In this connection, notice should be taken of the excellent work done for the indigent patient in our large metropolitan centers by county hospitals, medical schools, and charity clinics, medical care being, in many instances, rendered without any charge whatsoever.

Some idea of the value of this care may be gained from the estimate made of the services rendered by members of the Los Angeles County Medical Association to the indigent sick at the Los Angeles County Hospital during the year prior to World War II. Using minimum fees as the basis of such estimate, the figure of \$15 million for those services was estimated. When it is remembered that the total budgetary outlay for the institution for the year was \$6½ million, the value of these free services in comparison looms large if the taxpayer had been required to pay for them at the usual rates.

It is recognized that there are some rural areas where the health needs are not met with complete satisfaction, although these gaps are being rapidly closed. Further, the problem of medical care for the migrant farm worker is a difficult one, and one that as yet has not been solved completely. There are many factors involved, not the least important of which is the irresponsibility of the workers themselves. The Committee on Rural Health of the California Medical Association is giving this whole problem careful study and is prepared to make constructive recommendations in the near future.

Expansion of Voluntary Plans

What can be done to meet those needs? Certainly an expansion of any and all legitimate and responsible plans for the voluntary prepayment of the costs of illness ought to be encouraged. Just as free and unrestricted competition in the life insurance and annuity fields has resulted in the coverage of most of our citizens, so will the same type of enterprise produce the same salutary re-

sults in the field of voluntary health insurance provided too many roadblocks are not interposed.

Economic Base of Medical Care

However, a broader and more comprehensive answer to this question would seem to be in order. Just as the ideal economic state is one in which there is a maximum production and distribution of goods and services without artificial let or hindrance, so is the ideal system of medical care. Furthermore, there is an inescapable relationship between the two subjects, for medical care is inseparably integrated in our system of profit and loss or free enterprise.

If we are really sincere in our desire to give to the American people the best medical care at a price they can afford to pay, then we must recognize that government restrictions upon and intervention in the economic process in any manner whatsoever reduce the amount and availability of all goods and services. Price and wage controls, crop subsidies, agricultural allocations, rent control, all restrict the free flow of goods and services in such a manner as to deprive every citizen of the just and reasonable share to which he would be entitled if he were allowed to participate in a free economy unrestricted by any government order whatsoever, except that required to protect him from the predatory activities of his fellow.

Government manipulation of the currency, arbitrary abolition of the gold standard, and one hundred and one other capricious and unwarranted interferences with the economic and social freedom of the citizen all work toward a decrease of output and therefore a decrease in the availability of all the good things of this life, medical care being one of them. But this is heady wine, and of course far too strong a potion for our current voters who have been conditioned by 40 years of indoctrination for the Welfare-Police-Slave State. It will take another 40 or 50 years of hard work to return our country to any semblance of economic and social sanity.

Provision of Prepaid Medical Care

How can prepaid medical care be best provided? This question is best answered by the foregoing statement. It is our belief that there is no place for compulsion in any of these programs. A word is in order concerning a difference of opinion which exists in the prepayment field, some advocating complete or full coverage and others partial coverage or indemnification.

In any form of voluntary prepayment of the costs of illness, the insured person must be thoroughly aware of the cost of the service and must be responsible for its intelligent and economic usage. Certain restrictions upon abuses, such as payment of the first two or three visits in any given illness, are essential. More recently, a type of deductible insurance comparable to that employed in the automobile field has developed. This would seem to offer great possibilities inasmuch as the average individual does not require aid in the payment of minor bills but only in the case of catastrophic illness.

Government in Medicine

How much government in medical care—

a. *Veterans' Bureau.*—The medical activities of the Veterans' Bureau have always posed a serious problem to the private practitioner of medicine. Recognizing that at least 80 percent of those now receiving care in the Veterans' Bureau hospitals are there because of non-service-connected disabilities, it seems imperative that some means be provided whereby this unfair burden be removed from the shoulders of the taxpayer and its unfair competition be removed from the private practitioner of medicine. If the veteran with a non-service-connected disability is in fact indigent and unable to pay for this care, he is quite properly the ward of his local city or county political unit and should receive care at their hands. If, on the other hand, he is not an indigent, there is no reason why he should be occupying a bed and receiving care in a government hospital for a non-service-connected disability.

b. *For military dependents.*—It is believed that care can best be provided for military dependents by an expansion of the Blue Cross, Blue Shield, and private indemnity medical care plans.

c. *Hospital construction.*—In many instances, the effect of subsidization by federal money through the Hill-Burton Bill and/or state money has been so to increase the cost of such construction by the imposition of numerous and often unnecessary and illogical requirements, that the individual community benefits little if any from the subsidy. In addition, the community is often encouraged by the lure of such money which seems to be free, to build out of proportion to its needs and to find, when the hospital is constructed, that a white elephant is upon its hands with no means for its maintenance.

d. *In the case of psychotics, tuberculous, and the aged.*—At the present time, by far the greatest percentage of psychotics and tuberculous patients receive care in state or county institutions. This is not an ideal situation, but is one which has seemed to develop as a matter of necessity. The present care of the aged in rest homes and sanitariums, and other makeshift domiciles is far from satisfactory.

If we would remove from our economic system the present strictures to full production under which it labors, it ought to be possible in very short order so to increase our production throughout the economy as a whole as to provide under the private enterprise system ample care for all of these unfortunates. As proof of this, James F. Lincoln's "Incentive Management" is an excellent example of what can be done when private enterprise is really given an opportunity.

In view of the expansion of voluntary health insurance—in view of the expansion of hospital facilities in California in the last few years, coupled with the tremendous technical improvements that have shortened the duration of hospital stays and which have had the effect of doubling hospital capacity without increasing the number of beds—and in view of the number of physicians practicing in the state and their distribution, we submit that this area does not have any major unmet medical needs and there is no necessity or desirability for any additional federal legislation.

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Chairman WILLIAM P. SHEPARD. Thank you, Dr. Alesen. Will you wait just a moment before you leave? The members of the Commission may wish to ask some questions.

Views on Insurance

Commissioner RUSSEL V. LEE. Dr. Alesen, what is your attitude about insurance as a way of providing for indigent care?

Dr. ALESEN. You mean an insurance policy, Mr. Chairman, that would be purchased by a responsible organization—the city or county?

Commissioner LEE. By the governmental agency involved, instead of providing direct care through county hospitals, to provide the indigents with prepaid medical insurance of one sort or another. That is one of the approaches that have been offered to us.

Dr. ALESEN. As you know, Dr. Lee, we think highly of that. We think it is an area that should have quite a bit of experimentation before it is adopted, but I, personally, think it is good.

Statement¹ of

MR. JOHN C. FOSTER

Executive Secretary

South Dakota State Medical Association

Sioux Falls, S. Dak.

Social change does not come from the top down—from the politicians to the people—but rather from the people to the top. Therefore, we deplore any political insistence that progress must come from a paternal government rather than from the people themselves.

Basing our presentation on this premise, we feel that progress in health fields in South Dakota has been steady, satisfactory to the public, and spectacular, because it has been a product of individual initiative.

South Dakota medicine stands ready to meet all challenges that may come before it. We desire always to improve the health of our people and to cooperate in a better understanding of the facts of that improvement. We are proud that our state has one of the finest health records in the Nation and the world. We are equally proud that the men who practice the medical arts have led the way in establishing that record.

The problems that have arisen in the past are being handled effectively and efficiently at the state level.

In a rural area such as South Dakota it is necessary to maintain a distribution of physicians so that no one is completely out of reach of a doctor.

Through judicious use of DP physicians, and the effective Placement Service of the State Medical Association, medical care is now available to all South Dakotans. Every county with any population at all, and every trade area, has medical personnel using modern, well maintained equipment.

Medical Association Planned Programs

Through Medical Association planned programs, we are extending special care to two large segments of our population—the veterans and the Indians. These programs present medical care to these groups allowing them free choice of physi-

cian and the privilege of receiving such care in their home communities.

The recent creation of group practice in our larger communities, combined with airplane ambulance service and referral service from isolated rural practitioners, has given the people of South Dakota the best of medical service. We are proud that the present distribution of medical personnel has provided services that are satisfying health needs.

Hospital Beds Exceed National Average

Through sage utilization of our small hospitals cooperating with those in the larger centers, we have general hospital beds in excess of the national average. Our mental and tubercular beds are being increased by State appropriations.

Because of the rural nature of the State, industrial medicine is not a problem in South Dakota. Two industrial organizations are large enough to maintain health facilities, and both of them do—and one even maintains its own hospital facilities.

Medical Costs Over-Exaggerated

We feel that problems of meeting the costs of medical care have been highly over-exaggerated. A few isolated instances may be quoted that attempt to show the burden of medical costs, but the facts show that medical costs have risen much less in the past twelve years than the other costs of living—and more important—much less than the average increase in income, particularly in South Dakota.

“The medical cost problem” is an artificial one created by persons trying to sell their ideas to the man on the street. We endorse any voluntary plan that individuals may desire to spread the major costs of illness or injury, just as we endorse the frugality of the individual who saves some of his income for a “rainy day.” We urge the extension of voluntary prepayment medical care plans.

The South Dakota State Medical Association is a voluntary organization of doctors created to further the benefits of good health to all people in our area. Our field of endeavor has been to study problems as they arise, recommend change when necessary, and at all times to protect the rights and beliefs of the individual patient. Other agencies, less familiar with the problems and potentialities, have and are duplicating our work.

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

We endorse those who sincerely want to know the facts and are anxious to accept and use them; we condemn those who wish to use these studies for political gain.

Plea for Planning and Action

In closing, we would like to enter a plea for planning and action in all fields of health at the community level. America was made great on her farms, in her industrial plants—and above all, in her homes. To stay great those must be the sources of initiative in the future.

The people who spend their lives caring for the health needs of South Dakota must, of necessity, be more familiar with its health needs than any other group. The South Dakota State Medical Association is ready and willing to cooperate with any and all groups that may be sincerely concerned with the health of our people.

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Chairman GEORGE W. JACOBSON. As to your endorsement of voluntary plans, would that include endorsement of lay control plans of cooperatives like the one at Winter?

Mr. FOSTER. Well, the one at Winter failed, so we would not endorse that. I would not want to say that we would give a blanket endorsement.

Mr. JACOBSON. I am speaking of the principle.

Mr. FOSTER. In principle, we endorse any plan which comes from the people and the community in which they live, yes, sir.

Statement¹ of

DR. WILLIAM L. BENDER

Chairman

Northern California Advisory Committee

Selective Service System

San Francisco, Calif.

As you probably know, the doctors' draft law was passed about two years ago, in 1950, which provided for the registration and induction of all physicians, surgeons and veterinarianians, and allied specialists, under the age of 50 years. The Act also created a system of advisory committees to which the Selective Service System was to turn for advice regarding the relative importance of the members of these professions in civilian practice as compared with their importance to the Armed Forces.

The Northern California Advisory Committee, which is the parent of that advisory system, has supervision over the 46 Northern California Counties. No individual in that class is inducted or notified that he is to be inducted into the Armed Forces by Selective Service without having first had his name referred to us through the Northern California Advisory Committee for recommendation for or against his availability. So all cases of entry into the Armed Forces filter through our office. The Selective Service System does not have to take our advice, but it must listen to it, and we have a very good record of acceptance of our advice by the Selective Service.

Doctor Draft Analyzed

On June 30, 1952, a table on the experiences of the doctor draft on the national level was published, and on July 31, 1952, the Northern California Selective Service System published the figures for Northern California. I have analyzed both of those tables. . . . I am not allowed to present the figures in an open meeting like this.

However, I can say from the results of that analysis that a very appreciable percentage of physicians and dentists have been withdrawn from civilian practice in the 46 counties of Northern California to enter the Armed Forces, with little if any dislocation of adequate health services in this area. It is perfectly true that there have been some inconveniences; there have been dislocations; there have been curtailments. But in no case that has come to my attention—and I feel quite sure that I would have heard about it if there had been any, because we are the office which receives all complaints—have there been any important dislocations or impairment of adequate health services.

This is a very important observation, because it means that the services must have been adequate to start out with in order to absorb an appreciable loss of such services and still maintain a state of adequacy.

Physician Ratio

It will surprise you to know that there is one physician to every 350 inhabitants of San Francisco. There is one physician to every 635 population in Northern California.

I have eliminated in the next figure the San Francisco impact, feeling that that might stack the odds in favor of the doctor-population ratio. But I find after eliminating San Francisco that

¹Delivered at the Regional Hearing, San Francisco, Calif., September 29, 1952.

there is still 1 physician to every 758 inhabitants of northern California. That is a very healthy and adequate physician population ratio. We in the advisory part of the Selective Service are doing our best to maintain it. A program is under way which will replace returning veterans as they finish their tour of duty in the places of physicians whose turn it comes to serve their country in the Armed Forces. By means of such a rotating program we feel that the already adequate services of the physicians and dentists will continue to be maintained.

In conclusion, I think there are two things that can be stated definitely. There is an adequate physician-population ratio in northern California.

Secondly, there is an effective standard of health services, not only available but used by the citizens of northern California, as evidenced by the excellent health record that this area enjoys.

Statement¹ of

DR. LOUIS W. JONES

President

**The Pennsylvania State Medical Society
Harrisburg, Pa.**

The healing arts professions have been challenged for decades with health problems and needs. Pennsylvania history abounds with instances where professional people have met and answered problems which were previously thought to be impossible to solve.

Local government officials have combined with citizens and professionals to answer further broader health problems. In 1905 the State government officials recognized the importance of health and established a Department of Health with a Secretary of Cabinet status. Since then the State has supplemented the activities of lay and professional organizations so as to meet the needs of all citizens.

Realistically enough, there are certainly some needs which have not been fully met but are fully recognized by those of us who are working in the field. With particular reference to those which your Commission feels prone to discuss we wish to place the following statements on the record.

Providing Health Personnel

We recognize a limited shortage in health per-

sonnel and are taking proper and sensible steps to provide additional physicians, dentists, nurses and technicians of all types. We believe that the apparent shortage has been over-emphasized by the Federal Security Administration in its advocacy of Federal aid to medical education. The General Assembly of Pennsylvania has provided funds for these purposes and voluntary contributions by donors have enabled our medical, dental and nursing schools to supply more trained professionals each year. This need, although not major, must be answered by a long-range program which is already providing results in this Commonwealth.

Public Health Units

Local public health units in Pennsylvania are presently being established with the availability of permissive legislation. . . . It is obvious that many years may pass before local public health units will be established throughout the entire state. This is only natural and time to educate the public must be given to all parties concerned.

Presently in existence are units in the City of Philadelphia and the City of Pittsburgh, and a more recent one for demonstration purposes is now established in Butler County. Local health needs in Pennsylvania have been and continue to be met by the host of voluntary organizations, lay and professional services in the field, and millions of man-hours voluntarily expended.

Medical Research

Current medical research activities in Pennsylvania are being conducted in medical centers with the generous aid of funds and foundations established by private philanthropy and under grants from lay organizations depending upon funds collected from the public by such organizations as the American Cancer Society, the National Foundation for Infantile Paralysis, and supported by funds from the State and Federal governments.

The need for additional research facilities has been recognized by the Medical Society of the state of Pennsylvania for many years. We have consistently but unsuccessfully introduced legislation into the General Assembly to provide impounded animals for medical research purposes. We shall continue our efforts to instruct the public regarding this great need.

We believe that research institutions in Pennsylvania are well qualified but need an adequate supply of experimental animals.

¹ Delivered at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

Hospitals

Hospital needs and facilities in Pennsylvania have always been met by the non-profit voluntary hospital groups. Two exceptions to this have been in the areas of mental health and tuberculosis control which have been taken over by the State government—the former under the Department of Welfare and the latter under the Department of Health.

Continued expansion of facilities over the last 25 years has made available, within a reasonable distance from any community, the best and most up-to-date hospital care which can be provided. Certain hospitals are being threatened with a shortage of funds because of the demand placed upon them for caring for the indigent, which are wards of the State. A study of these facts is presently being conducted and action should be consummated in the near future.

Health Insurance

With reference to the adequacy of present health insurance plans, this has always been a concern of the Medical Society of the state of Pennsylvania.

Individual physicians and county medical societies have publicly endorsed the principle of medical service rendered regardless of ability to pay. Through the efforts of our Society, medical coverage has been included in the program of the State Department of Public Assistance to afford individualized professional service to all the indigent.

In 1941 our medical society originated and temporarily underwrote the Medical Service Association of Pennsylvania (Blue Shield), supplying a means for all citizens to secure voluntary non-profit health insurance to cover catastrophic illnesses. This program has been expanded to include some home and office care and will continue to expand its benefits if left undisturbed. Prior to this, the Hospital Association founded what is commonly known as the Blue Cross, which provides hospital care for our citizens.

In conjunction with these plans private insurance companies for a number of years have made available hospital, surgical and medical expense policies. At the end of 1951, there were 8,221,000 people protected in Pennsylvania for hospital care; 4,726,000 covered for surgical procedures, and 1,924,000 covered for medical expenses. Although these figures do not indicate a total coverage of all citizens in this Commonwealth, the

phenomenal rapid growth, and the acceptance of these voluntary insurance plans by the people have proved without a shadow of a doubt that those who are really interested and need coverage can secure it and may thereby protect their families from excessive medical costs.

It should be borne in mind that a great number of persons receive complete medical service and hospital care in government-owned hospitals—mental and chronic diseases—as well as similar service and care provided by the Federal government for the millions in our armed forces during active service and in Veterans Administration hospitals.

Health Programs

Regarding the adequacy of Federal, State and local health programs, we believe that stress should be placed upon local, county and regional participation. Without the understanding and cooperative support of the local public no health program can be successful nor maintained at high levels of professional service.

Where funds are not available to meet local needs, the county and State governments should supply funds which are necessary. We believe that Federal subsidization of local health programs is rarely necessary but that if the money was not drained off from local communities by high Federal and State taxes, community and county funds would prove adequate for both preventive health measures and for sickness service.

Statement¹ of

DR. J. W. THOMPSON

President

Missouri Medical Association

St. Louis, Mo.

In considering the question of health needs, it is most important to recognize that there can never be a final and complete fulfillment of the needs of human beings in the field of health. We are concerned, therefore, with a relative rather than an absolute question. In the field of health we have to do with progress—and the rate of progress—toward a goal that, by definition, can never be reached.

The function of health care and the purpose of supplying health needs is to defer death for the

¹ Delivered at the Regional Hearing, St. Louis, Mo., September 15, 1952.

longest possible term. The science of medicine will always be progressing, but it will always be faced with a great residual unknown, which is to say, there will always be an area of health needs beyond the power of the physician and of society to supply.

If it is agreed that we are concerned with progress toward better health and longer life, our inquiry must be centered on the question of how we are progressing and at what rate. For the state of Missouri, as well as for the Nation as a whole, impressive objective data are available. In the 50 years since 1900, the population of the state of Missouri has increased from 3,107,000 to 3,955,000, or roughly an increase of 27 percent.

Basic Change in Rural Life

The last decade or so has seen a basic change in the pattern of rural life. The development of hard roads, the general use of automobiles, and the continuing improvement in rural economic circumstances underlie the important change that has occurred. In terms of medical service, this means that the availability of a doctor must no longer be measured in terms of miles, but in terms of minutes. By such a measurement we may confidently assert that the people in all parts of Missouri are better served by the medical profession today than at any time in the past, and the availability of medical service is constantly improving.

This is not to say that there are not some areas in Missouri in which additional doctors are needed for the convenience and better service of the people. Progress toward meeting this need has been impressive since the war. Since January 1, 1946, the records of the State Medical Association indicate that a total of 494 physicians have taken up practice in areas of the State outside of the two metropolitan population centers. . . .

Of the total number of physicians who have taken up practice in outstate Missouri since the war, 324 have settled in smaller communities.

Distribution Progress

To sum up, the association believes impressive progress has been made toward a better distribution of medical service throughout the state and that this progress will continue.

The knowledge, materials, equipment and technical assistance available to the practicing physician today enable him to do more effective work in less time than was ever possible before. It has been stated that a generation ago physicians spent

only 30 percent of their working hours actually seeing patients. At the present time, the percentage of working hours spent with patients is now reported to be 90. The net of this fact is that a greater volume of better medical service may now be provided by fewer doctors than was previously the case.

Important to the maintenance of standards of medical service in rural areas is the program of the State Medical Association to bring to doctors in all parts of Missouri periodic refresher programs to keep them abreast of new techniques and new developments. This year-in-and-year-out program has a direct bearing on the effectiveness and efficiency of medical service throughout Missouri.

A final word on the supply of doctors: The decision of the Board of Curators of the University of Missouri to proceed with establishment of a four-year medical school may be expected to make an important contribution in years ahead.

Cost of Medical Service

There has been widespread recognition in the state of Missouri, and particularly on the part of the medical profession, that the prepayment principle is the essential key to progress in this area of health need. Recent years have seen extraordinary development of prepayment plans in the State. Others have made detailed statements as to the growth of these plans. I should like simply to state here that the two hospital plans serving Missourians now have a total enrollment of 1,254,663, and during the year 1951 paid out a total of \$15,705,023 for service benefits.

The two medical service plans have a total membership of 617,765, and during 1951 paid out \$4,973,158 for service benefits.

Intensive efforts continue to be made to extend these plans in the direction of ever greater benefits and to make possible more complete enrollment. In this effort there has been splendid cooperation between doctors, hospitals and farm, business and labor groups. Missouri is making impressive progress toward the solution of this economic problem.

In outstate Missouri I believe I can say with confidence that the people are now being taken care of. An overwhelming majority of them are being cared for on a basis that poses no critical economic problem. Studies and efforts continue to be made by local initiative and planning by

groups of many sorts throughout the State to make even further progress here. These efforts are going to succeed. In the interim the doctors of Missouri are taking care of the people of Missouri, and no one is going uncared for because he cannot pay.

To put it simply, there is no crisis in this question of cost of meeting health needs that warrants any turning away from the pattern of voluntary cooperative and individual effort at the local and State level. There is no crisis requiring intervention by the Federal government or imposition of a compulsory health insurance program involving the drastic step of putting physicians on the Federal payroll.

Physical Facilities

Modern medicine requires bricks and mortar, equipment and a wide range of facilities unknown to the doctor's office and simple rural hospital of a generation past. The supply and quality of medical service in rural areas depend very largely on the quality and availability of such physical facilities. The tools with which to practice are necessary to a scientifically educated doctor of today, and he is naturally reluctant to go where these tools are not available.

The past decade has seen rapid progress in improvement of the resources of outstate Missouri for health service. This progress has been particularly rapid since the enactment of the Hill-Burton legislation to aid local efforts for hospital construction.

Within the past decade an impressive number of new hospitals have been constructed or projected, some of them involving use of Federal funds to match sums provided locally, and many others made possible entirely by local funds.

These improvements in public hospital facilities have been supplemented to a very great degree by clinics and diagnostic set-ups provided by practicing physicians. It is not an over-statement to assert that Missouri is going forward at a most encouraging rate in extending the effectiveness of scientific medical care into every part of the State.

Exciting Progress

It is the view of the State Medical Association that the progress of Missouri—very briefly noted in the paragraphs above—is impressive. The association believes deeply that the voluntary methods by which this progress has been achieved—with the help of governmental agencies in appro-

priate circumstances and, particularly, for hospital construction—have proved themselves to be methods conducive to great results.

These voluntary procedures accord with the needs of our people and with the processes of local democratic action, local initiative and local responsibility that are part of the pattern of our civilization. The Medical Association submits that there has been no failure from these methods, no breakdown, no halt in steady progress that would justify a drastic departure from our tested past practice. On the contrary, this practice has produced progress of the most exciting kind, and it promises even greater things for the future.

Statement¹ of

DR. FRANCIS T. HODGES

**(Representing Academy of General Practice)
San Francisco, Calif.**

Dr. Lee, Dr. Shepard, Members of the Commission: Before I can bracket anything with parenthesis, I have something parenthetical to say. It occurred to me that in all of these problems that we are considering, a most basic factor, and important to the entire problem of medical care, is a reexamination of our responsibility to ourselves. We must get back to individual acceptance of responsibility as our right and duty, not search merely for an agency or a governmental organization to take over from us the problems that deserve our own thought and energy. I feel that this basic attitude is of prime importance.

Few Unmet Health Needs

California is particularly fortunate in that its unmet health needs are few. This is eminently so in the metropolitan Bay area, with an abundance of excellent hospitals, clinics, and two of the top ranking medical schools. The number of physicians is adequate for care of the population. Here, a need is apparent to me, if I may borrow a phrase from Dr. Stanley Truman, that of a "balanced medical community."

Time does not permit my reviewing the history of over-emphasis on specialization tremendously accentuated since the war but, whatever the causes, the ratio of specialists to general practitioners has exceeded that which is in the best public interest. The need here, as elsewhere, is for more well trained, competent general practitioners.

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

I argue that there is no true shortage of physicians, but a relative shortage, dependent upon two conditions. The first is an excess of specialists, the second is improper distribution.

Plea for General Practitioners

An immediate easing of the apparent shortage of physicians would take place if many of those limiting their practice, and who are not overly busy, would serve where they are truly needed—in general practice. Their special skills would still be available, as would their services, now in broader fields.

If they could be convinced that they need not confine themselves to a single field because of their special training, and if they could be convinced that as general practitioners they would occupy positions of honor and competent responsibility, there would be more good men in this field rich with the reward of their patients' gratitude. I wish that more physicians could know the great desire of most people to find a personal physician—a family doctor.

The reshuffling of the medical talent would eliminate the medical bottleneck. It would cause no congestion at the specialist level.

Much of what is now needlessly taken to the specialist could be adequately treated by an expanded panel of general practitioners, while there would still be the vitally essential lists of specialists for consultation, referral and assistance.

Return to Personal Relationships

The return of personal relationship to medical practice—too often praised, sometimes lacking—would do much to reduce a desire for State medicine. The savings to a patient in no longer seeking out a new physician for each type of ailment, with tedious expenditures of time for new histories and duplicated tests, would result in increased contentment with medical care. The ability to obtain 85 percent of one's medical care in one office, with one man, in the role of friend, would quench many doubts as to the adequacy of the job American medicine is doing.

That there are not considerably more self-confessed general practitioners is due in part to the trend to surround specialization with a man-in-white glamour. The workhorse role has been, in inference, too earthy, and an affectionate picture has been painted of a kindly, elderly, plodding semi-extinct family doctor, not abreast of the times. A series of articles in a large woman's

magazine has done probably more to undermine confidence in the personal physician than any other single influence in the past few years. It is implied that all of the evils from ghost surgery to fee-splitting to superficial symptomatic treatment are to be laid at his doorstep.

If the Commission desires to see examples of superior medical service by GP's to their communities I would be very pleased to point out to them an abundance of such examples in both city and rural locations in this area.

The answer to this first unmet need, then, is twofold. Encourage in all ways the return of the personal physician to his proper stature as a full partner in medical organization and the rest of the answer will follow—more of the profession now restricting their practice will return to general practice.

Medical Schools to Blame

A part in this artificial shortage must be attributed to the medical schools. All too few schools concentrate on what should be their prime duty, the training as well rounded physicians. Except for certain schools, such as Colorado, Kansas and Tennessee, this default appears to be by design, not by dereliction.

It seems especially incumbent upon the State supported schools to supply the primary need of the State's communities with adequately trained general practitioners. But few schools do this or desire it. General practice departments, instructing in the vital art of medical practice, are almost nonexistent, and in most schools in this State a student meets only specialists, teaching only specialties.

It is no exaggeration to say that graduating students speak often apologetically of a desire to enter general practice. That there is a deep desire is evidenced by statements made to me by many students after I have addressed them (in almost clandestine meetings) regarding the rewards of general practice. They are well aware of the gap in their training. They regret the assumption that the general practitioners are those left over after the bright young men have been selected for the specialty residencies.

General practice needs the honor students, and must not be considered the catch-all of the culls.

Re-examination of Teaching Curricula

This unmet health need, then, is a reexamination of teaching curricula with the goal of manufactur-

ing complete physicians as well as the needed specialists. This will require a greater leavening of the academic with the practical. A part of this practical approach must be a realization that "general practitioner" is not necessarily synonymous with "country doctor" or "rustic practitioner."

The "general" man in California, in most instances, occupies a relatively enviable position in comparison with his colleagues in some states, particularly on the Northern Atlantic Seaboard. His hospital privileges, a key to full medical practice, are excellent. . . . He is, in general, with the notable exception of some teaching institutions, acceptable to the hospitals on the basis of his demonstrated skills.

Let me point out that this is not the rule in the country, and that where medical guilds can exclude him to the furtherance of their interests, they will do so.

General Practice Department

One of the needs, partially met, then, is the existence of general practice departments on an equal footing with other hospital departments. The American Academy of General Practice has prepared a manual on the establishment of such departments for those Commission members desiring to pursue this further.

Integrated with such departments must be the establishment of carefully planned 3-year hospital services of internships and residencies in general practice so that personal physicians are made by plan, not by default. This is considered a vital need.

Preceptorships Advocated

Another need under intensive study by the Academy of General Practice is that for medical school approval of the principle of preceptorships, whereby junior students shall live and work with representative general practitioners during summer periods in order that they may learn at first hand how three-quarters of America's medicine is practiced.

The portion of this question relating to distribution of physicians is one that is not always easy to solve. California has less acute rural physician shortages than many areas, and some of the finest medicine is being practiced in obscure byways of the State. The communities needing physicians must first make it worthwhile for a physician to practice there.

The advantages and rewards are many. Few

citizens enjoy the civic position which is almost certain to be that of the community doctor. I feel that it should be the obligation of state trained physicians to consider placement in outlying areas which need physicians. Possibly scholarships could be arranged for those agreeing to such a plan. It is true that the experience of Mississippi has not been wholly satisfactory. City areas need general practitioners as well as rural ones.

Health Insurance

. . . As Secretary of this organization, I have arrived at some conclusions as to needs to be met before a greater segment of the population is satisfied with prepaid plans.

First, I am firm in my belief that no compulsory plan can approach a good voluntary plan. The evils of compulsion and Government control are too numerous to relate.

Secondly, I am sure that the public needs greater protection through insurance plans. Coverage must be broader—possibly not all inclusive—to avoid abuses—but surely sufficiently broad so that the patient does not have to worry whether he has a diagnosis that is covered or an illness that is curable before his coverage expires. There must be protection from bankrupting medical catastrophes.

Thirdly, the fee paid to the doctor must be on the basis of a fair fee schedule, not one that is only a token or a discounted fee, which assumes that the physician should be satisfied with it because he is more certain of getting it than directly from a patient. There must be open panels of doctors furnishing care.

The above conditions lead to the next two: the medical profession must at least agree upon what is a fair and average (not discounted) fee schedule for patients of average or poorer means, and then stand by such schedules. Excess charges above such fair pay will only discredit the profession.

Cost Will Be Greater

This leads to the final and most important condition: to furnish the foregoing, the cost to the patient is going to be far greater than any existing plans—it must be, but the results are what patients demand and need. Education of the public as to what can be expected for the medical insurance dollar, and education of the public as to its inescapable responsibility to itself must be preliminary to the presentation of really workable plans offering greater security.

When the public is ready to pay for medical care what it pays for whiskey, or for cigarettes, or for movies, then it will buy medical insurance intelligently. It will not respond except with confusion if medical insurance is presented as a cut-rate bargain, rather than a realistic way of "pacing" one's medical expenditures. I speak from my own convictions, not for California physicians' service.

Government in Medical Care

How much Government in medical care? In general, the less the better. Medicine is too personal to be regulated by fiat, decree or bureau. The Veterans Bureau presents the greatest potential threat to individual private practice. At the present rate of war-waging, it is conceivable that before long we will have a country of all veterans and veterans' dependents. The present attitude is to accept the perjuring pauper's oath at face value and render free service for every ailment. I dare say that the percentage of nonservice-connected disabilities is staggering.

I view with great uneasiness the mushrooming growth of new and unneeded veterans hospitals, and deeply suspect social planners of presenting these as the weapons to break the back of free medicine.

For service-connected disabilities, let home town care plans be utilized more and more, with the personal physician rendering the personal medical care really wanted by the public.

Military dependents, not veterans' dependents, should receive medical care from private physicians at government expense in time of war or national emergency.

Hospital Construction

Hospital construction must be as much of a community project as possible, and government aid must not be considered as the easy way for a community to rid itself of its own responsibility. Where government aid must be resorted to, let it be with the minimum of resulting government control. He who accepts from his government gives more in return, if he can only be astute enough to recognize it.

In the care of psychotics, the tubercular and the aged we touch upon three of the major problems of medical care. But should the care be a national government responsibility? I don't believe so.

The state and the community are better fitted to deal with these real and increasing (barring tuber-

culosis) problems. The role of national government should be in the conducting of research, statistical surveys, et cetera in these fields, not in the furnishing of custodial and therapeutic care.

Emphasis on General Practitioner

In summary, I plead for a return to general practice of many now specializing, relieving a false physician shortage. I say a false physician shortage advisedly.

I urge medical schools and hospitals to train highly skilled general practitioners by plan, not by accident.

I advise a "balanced medical community," with 30- to 40-percent qualified specialists, and 60- to 70-percent highly skilled general practitioners.

I plead for an organized place for the general men on hospital staffs.

I urge greater usage of the personal physician as one means of achieving more economical medical care.

I suggest that a new concept of voluntary medical insurance with greater coverage, greater security, a fair fee to the doctor; and if available at a greater premium rate it is not an impossibility, if the public is first apprised of the true facts of medical costs.

The time is ripe for less Government in medicine, not more.

Statement¹ by

DR. CYRIL J. ATWOOD

President

**Alameda-Contra Costa Medical Association
Oakland, Calif.**

I appear before you in my capacity as president of the Alameda-Contra Costa Medical Association. Alameda and Contra Costa Counties lie east of San Francisco Bay and contain more than a million people, who are served by the 1,400 members of this Medical Association.

I have two purposes in coming before you today. The first is to describe one of many areas where universal distribution of doctors' care exists for all the people in that area. The second purpose is to use this example to remind all who are concerned with the problem of the distribution of medical care that seldom is the problem of the patient one of availability of doctor care, but

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

rather of hospital care, nursing care, drugs, appliances, and other incidentals to illness.

We do not appear here to extol a "unique bright spot" in the field of medical care. We differ from other areas only in that we have placed ourselves in a position to prove what we know exists generally throughout the country. We know it is not true that people lack the services of doctors. All we have done in our counties is to organize already operating facilities so that we can prove this point.

Unconditional Guaranty

Our members have assumed responsibility for making their services available at all times and under all circumstances to all of the people. We have so organized ourselves and integrated our work with voluntary and public agencies that we now, and have for years, repeatedly published an unconditional guaranty of "medical care for all, regardless." By medical care we mean the services of doctors of medicine. Through advertising in the daily press, through radio programs, through the distribution of nearly 200,000 pamphlets, through publicity given to us by way of articles in *Reader's Digest*, *Woman's Home Companion*, *Newsweek*, *Nation's Business*, *Catholic Digest*, *Everybody's Digest*, and every other medium of publicity at our command. We have told all in our area of the public service of the profession, as given through the work of doctors as individuals in their offices, and, collectively, through their medical association.

All of our communities are covered by a round-the-clock telephone answering service advertised in the classified telephone directory, so that we can and do provide the services of physicians in emergencies around-the-clock, 7 days a week.

The Personal Physician

Specifically, we ask people to see their personal physicians if they need medical care for which they believe they cannot pay. Usually the problem is solved here, but where the personal physician is unable to solve the problem of the patient or where the patient has no family doctor, he is asked to come directly to the medical association.

We have a full-time qualified medical social service consultant. Her function and philosophy is toward helping people help themselves. After consultation she may refer the patient to a public or voluntary resource. Where no such resource is available for the patient's problem, the patient

is referred to a physician member of the patient's choice, or if the patient has no choice, to a physician assigned in rotation. The physician is told the facts in the case by the social worker and agrees to handle the problem at a price the patient can afford to pay, as determined by the social service work-up—a reduced fee, or, where necessary, gratuitous service.

Public and voluntary agencies are kept aware of the medical association as a resource and very frequently use it.

Social Service Department

A close tie-in is maintained with the county hospital social service department. From there, by arrangement with the medical association, patients who are unable to qualify for county care and are unable to pay the full cost of medical care are sent to physicians of their choice, or if there is no choice, to members of the association in rotation along with the social service work-up.

Again, the doctor treats the patient for a fee within the amount the patient is determined to be able to pay by the county social service worker. Inasmuch as our members in private practice staff the county hospitals, patients qualifying for admission are treated by them without charge to the taxpayers. When they are not eligible for county care they are treated, perhaps by the same members, in their own private offices at a price they can afford to pay. Thus, we back up our guaranty of "medical care for all, regardless . . ."

Bureau of Medical Economics

Additional steps are needed, however, to protect the patient from economic injustice on the part of the physician. We have set up what we call our Bureau of Medical Economics. People may apply to the Bureau for assistance in advance of the needed treatment in which case their problems are met in the same way as described earlier. But very often people are unable to pay for treatment they have already received, and in most cases adjustments are made by the physician in the traditional manner.

In other cases, however, people fail to state their case to the doctor, fail to pay and fail to inform him of their reasons for nonpayment. For this reason, the Bureau of Medical Economics operates a collection agency. Members of the association refer their unpaid accounts to the Bureau,

which operates under the control of the medical profession and its ethical standards. Specifically, the patient whose unpaid doctor bill is referred to the Bureau receives a letter something like this:

"If your problem is one of financial hardship and you are unable to pay this bill, please contact Mrs. Muriel Hunter, Medical Social Service Consultant of the Alameda-Contra Costa Medical Association. If yours is a case of genuine hardship, the fee will be reduced to an amount you are able to pay, even if that amounts to complete cancellation of the bill. We represent ethical physicians."

Also, our doctors maintain committees to handle, in the public interest, the problem of the patient who believes he has been over-charged. An excessive fee is defined as one that is either greater than the value of the service rendered or greater than the ability of the patient to pay.

Voluntary Health Insurance

This work by our doctors would not be adequate in the absence of the voluntary health insurance plans. But this supplementing the voluntary plans—assisting people who have not availed themselves of these plans, and tempering the doctor's fee in accordance with the ability of the patient to pay when the plans do not meet the needs of the patient—we feel that there are no unmet needs for the services of physicians and surgeons in the area for which we are responsible.

Although we guarantee only the services of doctors of medicine, we are, almost without exception, able to meet the other treatment needs of patients through the cooperation of governmental and voluntary agencies throughout the community. These other needs in our communities, particularly for various types of hospitalization, I will not discuss here today because I understand these problems will be covered by others.

I wish, however, to impress upon the Commission these facts: One. That the unmet need of people in most communities is not that of getting doctor care but rather that of ancillary services and facilities. Any realistic approach to the problem on proper analysis, which includes breaking the problem into its components of doctor care, nursing care, hospital care, drugs, appliances and the like, will reveal that few people in any community, and none in ours, need go without the

services of a physician just because he cannot afford to pay, and that the voluntary plans increasingly cushion the patient's economic shock.

Local Medical Society Program

This proof of assumption of responsibility by local medical societies is spreading rapidly throughout California. It is a project of the California Medical Association, on which several full-time people are working, to achieve this proof of universal distribution of doctor's services to everyone in the state of California. This type of program is also in effect in many eastern and middle-western communities and is rapidly spreading.

The second point I would like to impress upon the Commission is that when the total problem of medical care is considered and sensibly broken into its component parts, this type of program, plus voluntary health insurance, makes unnecessary further government interference with the solutions provided by insurance companies, medical associations, and present public agencies, through their medical care distribution plans. At least in the area where our Association operates and meets its responsibilities, there is not now and has not been for years a single person who could not get the services of a doctor of medicine merely by asking for them.

We invite a closer inspection and examination by this or other interested groups. Unbelievers in the past have visited us and examined our records and handling of cases. Ours is not a perfect plan nor is it perfect in its operation, but we are daily working to achieve perfection. We do not satisfy all people nor could any plan or procedure satisfy all people, but we do satisfy all real needs of people.

In closing I would like to emphasize that I, along with any other reasonable person, believe that any real human need that cannot be filled by individuals themselves, or by their local co-operative initiative, must in the public interest be filled by higher echelons of human cooperation, including the Federal government.

But in the case of doctors' care this problem has long been solved individually, locally and voluntarily. To indulge in an oversimplification: Nobody in America dies in the streets because doctors refuse him care. Insurance companies, medical associations, local public agencies and scores of voluntary local agencies are increasingly effective in spreading this availability of the doctor's serv-

ices. Governmental involvement in this progress can only slow it.

County Medical Council

Commissioner RUSSEL V. LEE. Dr. Attwood, could I ask you a couple of questions? Your county society is a very famous society for progressive action of this kind. Have you a medical council operating in that county?

Dr. ATTWOOD: Yes, we do have one, Dr. Lee; the Council representing the component parts of both counties is the governing, the ruling body, the policy-determining body of our society. My function as president is to carry out their wishes, policies and desires.

Commissioner LEE. Does it maintain any continuous liaison with other groups in the community interested in health matters? I mean, such groups as labor groups, racial minority groups, and people of that kind who are interested in health affairs? I mean, do you have any continuous relationship going on there?

Dr. ATTWOOD. We have no official connection, in the sense that we have in our constitution of our organization any binding agreement with them, but I might say that our Council meetings, which are held once a month, are quite open, and anyone wishing to be heard or present their problems on the medical situation to the councilmen may come forward and do so. They are welcome to do that, and their suggestions and problems will be very carefully considered by the Council.

Medical Competency and Standards

Commissioner LEE. Another question. One member of our Commission, not present here today, has been seriously concerned about the number of physicians who, by reason of superannuation or congenital incompetence or something, are no longer capable of practicing, and thinks that is a considerable problem. Does any mechanism exist on the part of your society for the elimination of such individuals? It is a very real question.

Dr. ATTWOOD. I don't believe it has, Dr. Lee. I am giving a sort of off-the-cuff answer to that, but I believe that would have to revolve around the responsibility and the action of the State Board of Medical Examiners, would it not? The County Society has no power to remove the license of any physician. It couldn't assume that responsibility; it doesn't have it.

Commissioner LEE. Do you have some sort of professional standards committee, or something of that sort, that passes on such matters?

Dr. ATTWOOD. Yes, we do. We have, as a matter of fact, 54 committees altogether that work on all sorts of problems. The fundamental thing they all work on is the distribution and quality of medical care. The county society, of course, has no authority to stop a doctor in his practice. If his practice is not in keeping with ethical standards, then it can and does remove him from membership in the society, subject to an appeal by the state society and the AMA, and it cooperates with all efforts from hospitals and other societies in raising the standards, but it has, I believe, no legal power as an organization to remove a doctor's license to practice.

Commissioner LEE. No, of course not. This has been thrown at us a number of times in Commission hearings. We are interested not only in the quantity of doctors but their quality, and I just wanted you to comment on the possible methods by which that problem might be met and whether you think there is much of a problem.

Dr. ATTWOOD. Well, I can assure you of this: That such information about an unqualified practitioner that the society, specifically its Council, felt was a detriment to the care of the sick and injured in the community, would be forthcoming gladly to the State Board of Medical Examiners for their action as they should see fit.

Racial Discrimination

Commissioner LEE. Do you have any comment on Mr. Jeter's remarks about racial discrimination in your area?

Dr. ATTWOOD. Yes, I would like to make some comments on that. I am afraid they may not be completely adequate. I would like to comment, if I have a minute or two, that I have been in two capacities.

At the present time I am head of the Department of Radiology in two hospitals, the Administrator of one of which is here this afternoon and will speak to you in a few minutes, and that hospital has a colored resident. It is one of the hospitals with a large volume of heart patients.

Over the years that I have given service there they have changed very much, partly because of population changes, I suppose, but at the present time—I am not going to give you any figures—but I do think that at least half of those patients are

of the colored race. The other hospital that I serve has, at the present time, as one of its supervising nurses on the busiest floor, a colored nurse, who is very well thought of everywhere, and neither institution that I have personal experience with as a practitioner has any racial discrimination whatsoever.

Now those are only two hospitals in the community. To answer the broader question that has been brought up, I am afraid that I haven't all the information that I should have, but speaking as the president of the society, I can definitely state that over the past two years, as vice-president and president, I have no knowledge of any objections being brought to the council for consideration or of the problem coming up in any way.

I was a little, quite honestly and frankly, taken aback by the speaker preceding me, because it was quite honestly entirely out of my thoughts, and I didn't know that any objection had ever been raised in our county. Now, I may have heard of it, but I am sure that it was not brought to the council's attention during the past two years that I have been a member of the council.

Statement¹ of

DR. JEROME I. SIMON

President

St. Louis Medical Society

St. Louis, Mo.

My name is Jerome I. Simon. I am engaged in the private practice of surgery in the city of St. Louis, and am the 1952 president of the St. Louis Medical Society.

In presenting these views to this Commission, I should like, first of all, to make it clear that I appear today as a private practitioner and a citizen of St. Louis, and not in the capacity of spokesman for the St. Louis Medical Society. It was obviously impossible, in the short time available for the preparation of this statement, to consult each and every member of the local medical profession in order to present a collective opinion. I think it is safe to say, however, that my personal observations will represent the opinion of the average doctor in this area, whose full-time efforts are devoted to the care of those who come to him for diagnosis and treatment day in and day out.

Medical Resources of St. Louis

About 2200 physicians are available to the 857,000 residents of the city of St. Louis. There can be no question, I think, of the adequacy of medical coverage in the area. Others, I am sure, will discuss this coverage outside the city. We boast of two top-flight medical schools—Washington and St. Louis Universities—which, together with our voluntary and municipal hospitals, our fine Health Department, and our Medical Society, furnish clinical facilities and competent staffs to care for the indigent and low-income groups of the city, as well as to provide a continuing program of health education to the public and postgraduate programs to our doctors. For medicine is not a static science, but one of ever-changing concepts and new discoveries, which made it mandatory for the modern physician to acquaint himself constantly with that which is new and to maintain a close liaison with those educational sources that will keep him current and in a position to be of the greatest assistance to his patients.

St. Louis is fortunate in having an outstanding Health Department, under the capable administration of Dr. J. Earl Smith. This important section of our municipal government provides and supervises many vital services in the area. It is not my province to enumerate these activities, but I shall take the liberty of mentioning the great value of its neighborhood health centers, its new Mental Hygiene program, its venereal disease educational program, its Health Education section, which provides a Weekly News Letter to approximately 1,800 recipients, including newspapers, radio stations, physicians, schools, hospitals, and many social and voluntary health agencies in the area. Its record in the field of communicable disease control ranks high in the standards of health control measures and the high level of its standards for food sanitation in restaurants has been equalled by few cities in the Nation.

Health Education

In the matter of health education for the public, there has been increasing interest manifested by ever-increasing attendance at the Medical Forum meetings in the St. Louis Medical Society Auditorium. Each month, a panel of Medical Society members who are experts in special fields such as arthritis, cancer, heart disease, diabetes, etc., discuss these topics for public audiences. The question-and-answer method has proved to be very pop-

¹ Delivered at the Regional Hearing in St. Louis, Mo., September 15, 1952.

ular in these meetings, and there is every reason to believe that these programs will continue to grow in public approval and interest.

The voluntary health agencies of the city number many physicians on their boards, and the cooperation of the Medical Society has always been available to those agencies which seek it.

Other Aspects

An Emergency Call Service is in operation in this city, and the medical telephone exchanges have lists of volunteers from the Medical Society and the Academy of General Practice who stand ready to deliver such emergency service on call.

Time will not permit full discussion of the many facets in the improvement of the public health in which local physicians are participating. I would not be so foolish as to contend that medical service in the city of St. Louis has attained the peak of perfection. I do maintain, however, that the local medical profession is constantly alert to opportunities for greater service to the public, and is always mindful of its responsibilities in the field of public health. To mention but a few, its activities in tuberculosis surveys and in the detection of diabetes are excellent examples of a great public service.

It seems to me that there are no deficiencies or inadequacies in this area that cannot be solved and remedied on the local level and by voluntary action. The deficiencies that do exist—in our municipal hospital care, for example—can be laid at the door of political rather than medical defection. For there are more votes to be garnered by appropriations for parks and streets than can be gained by increasing the allowance for the city hospital. In my opinion, this is a matter for municipal—not Federal action.

Federal Funds

I should like to take this opportunity to express a private citizen's opinion in the matter of Federal funds. Federal money is everybody's money. It is your money and mine, and it comes from the man in Portland, Maine, and the man in San Francisco, Calif. None of us complains about expenditures that are vital in the national interest, whether it be national defense and the Marshall plan, or whether it be salaries for immigration and quarantine officers in our seaports. In the matter of increasing funds for the St. Louis City Hospital, however, it seems to me that the man in Maine and the man in

California have just cause for complaint when the Federal government authorizes the use of their money to correct a situation in St. Louis that St. Louis can and should correct itself.

Of course, I am not overlooking the benefits of such measures as the Hill-Burton Act in those regions where the limitations of population or local resources render the establishment of health and hospital facilities impossible on a voluntary basis. It is entirely possible, however, that more participation in these enterprises could be made at the State level. In short, with few exceptions, Federal hand-outs for local projects accomplish nothing but the postponement of that happy day in the too-distant future when a tighter string on the Government's purse will point up the responsibilities of local political authorities.

Statement¹ of

DR. ROGER L. J. KENNEDY

President

**Minnesota State Medical Association
Rochester, Minn.**

Before discussing health needs, it is necessary to point out that this Nation is one of the healthiest in the world, and that Minnesota is one of the healthiest States.

The Minnesota State Medical Association respectfully accepts your invitation to participate in the regional meeting of the President's Commission on the Health Needs of the Nation.

* * * * *

Medical science has proved itself. It has worked hard and long, and continues to do so, to provide for people the best facilities and opportunities for good health in the world. The health of the people is of utmost importance to the physician.

Medicine Creates Paradox

So the doctor and medical science have created a paradox. It is this:

While working incessantly to conquer diseases and improve the general health picture, they have increased the life span to a high point, thereby giving man more years of later life.

Along with this increase in the number of older people in the population, medicine is confronted with more and more cases of chronic illness and

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

senility and the entire difficult area of disease control in aging people.

Since 1900 the average length of life in the United States has increased from 49.2 years to 67.2 years in 1948. Additional proof of this is seen in the figures which show that at 1940 expectancy rates 80 percent of the population would survive to the age of 50, compared to only 59 percent in 1901; and that at 1940 death rates, 46 percent of those aged 50 years would reach 75.

So another health need has been created. And the physicians have recognized that need and have been doing something about it. Better treatment of chronic cases has been encouraged, and careful thought put into the close relation between senility and mental illness. More research into this field is in the process of completion. The Minnesota State Medical Association's Committee on Chronic Illness has been active and is working with other groups to help in creating better care for the aged, thereby working to prolong life ever further.

Accidents

In spite of the fact that there are more people in the United States each year, a large number are killed annually from accidental causes. Minnesota doctors feel that one of the most important aspects of this situation is the continued help from all Americans in reducing this frightful toll from accidents.

We have done much in the past, but I need only to point to the number of accidental deaths occurring during this past Labor Day week end to show that more can be done. This is necessary not only on the streets and highways of this country, but in the home, on the farm and in the factory.

All this excellent medical care is fine for the people, yet the question is asked, "Can they afford it?"

It would seem reasonable to say that they can, because the cost of medical care in the United States has not gone up as far or as fast as the cost of living.

Thus, if Americans can afford other necessities of living, they should be able to afford medical care, which has been proved to be less expensive.

What does it cost? A fair answer can be obtained from the voluntary prepayment plans.

Voluntary Prepayment

Blue Shield and Blue Cross have shown that a reasonable protective plan can be purchased for an amount that can be afforded by the employed

person and his family. This includes hospital care, surgical, medical and obstetrical care.

As of 1949, the cost of medical care, including drugs, was 45 percent higher than in the normal years of 1935-39, while cost of living was up 69 percent. It is interesting to note that in 1948 the American people chose to spend slightly more for alcoholic beverages, and for recreation, than for medical care. The amount of the average budget spent for physicians' services was about half as much as the amount spent for tobacco and slightly less than the amount spent for personal care.

It has long been known that the financial pinch comes when a person has to pay for a sudden illness of major proportions. And in this line, too, doctors have seen the need for providing a means by which people could insure themselves against these overwhelming costs.

With that goal in mind, doctors formed their own plan of aiding the payment of these costs, by developing the Blue Shield prepayment plan.

It is well to keep in mind that doctors, although they are not insurance men, have provided a means by which low and moderate income groups can obtain adequate protection against the cost of illness.

It is also notable that the plan is still very young and is in the growing stage. Although Blue Shield has issued coverage to more than 500 thousand Minnesotans in its short four and one half year history, and its companion plan, Blue Cross for hospital costs, has covered over one million people in Minnesota, there are still a few improvements to make in the working of these plans.

Continuous study is being made and it is anticipated that extension of the plans will be realized. Meanwhile the present plans are growing quickly. In addition, the commercial insurance companies have developed excellent health policies which cover another large segment of the population.

Physician Shortage

Doctors have been among the first to understand the consternation expressed by people who would like to see more physicians in the State. Those people insist that rural areas are completely devoid of the services of physicians, when further study would reveal that this is not true to the degree they claim. What is true is that physicians tend to congregate in populated areas, just as industries do or just as lawyers do.

It has long been stated and reiterated that the physician shortage is more a problem of distribu-

tion than of actual numbers. At the present time, Minnesota is provided with one doctor to approximately each 700 people—an average which is better than the national average. And the national average is the best in the world. From 1930 to 1950 the population of Minnesota increased 16 percent; during the same period of time the number of licensed and registered doctors of medicine increased 28.7 percent.

And, because the problem seems to be one of distribution, there are ways to meet that health need also.

Doctors of Minnesota have provided a service whereby communities needing a doctor can secure one through the Physicians' Placement Service, operated by the Minnesota State Medical Association. Complete lists of physicians seeking locations and locations seeking physicians are kept up to date and an exchange procedure between the two groups is used.

Excellent reports have come from the service rendered by this system, and it is just one more way in which physicians themselves are working to meet the need they themselves have already recognized.

Physician Training

Another method of meeting this need is the actual training of more physicians. Along with encouraging expansion of training facilities at the University of Minnesota Medical School, the Minnesota State Medical Association has created a Rural Medical Student Scholarship Fund. This fund provides \$1,000 per year to the students who in return will promise to practice for at least 5 years in a town of 5,000 people, or less.

Also, the national emergency is another factor in the complex situation. About 130 Minnesota doctors are now in the military services who would otherwise be available to fill vacancies in areas throughout the State.

It is reasonable to assume that with increased training of physicians and the return of those from active service Minnesota will be more than adequately supplied with the services of physicians.

Survey Criticized

We, the physicians of Minnesota, feel that the short time allotted to the medical profession to cover the subject of health is entirely inadequate. We also strongly feel that the hearing itself has been poorly timed; that it is placed in the middle

of a heated election campaign when testimony can be used for political purposes; that it is political by intent and nature, a product of those political forces which have constantly drummed the idea into citizens of our country that medical science and the doctors of the Nation have not provided adequate health needs and who assert that the government can do better; that there is really no situation existing in the health of the Nation today that warrants this type of a survey, and especially one which is conceived in such a rapid and haphazard manner, which cannot possibly hope to acquire an accurate picture of possible existing health needs, meager as they have been proved to be.

We believe that the health needs of the Nation are not overwhelming, that they are being solved by the continued efforts of men of medicine and related fields who are free to practice and work without interference and control, that future problems in this field will be solved most completely and most satisfactorily by a medical profession which remains free to continue its earnest quest for even better health for all people.

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Commissioner MARION W. SHEAHAN. Thank you, Dr. Kennedy.

Commissioner CLARK. Dr. Kennedy, this morning we heard from the community hospital in Two Harbors that their staff, who are graduates of Class A medical schools, and licensed to practice in the State, were unable to obtain membership in the medical society and felt under a severe handicap because of that.

We also heard from the Wisconsin Medical Association that they had supported a bill in Wisconsin for an enabling act for such cooperative ventures.

Then we heard from the Medical Association of South Dakota that it had no objection to such cooperatives, and I wonder if you could tell us if it is true, as reported to us, about the condition that exists in Minnesota, as it was described to us?

Dr. KENNEDY. I am glad that you have asked me that question, because it emphasizes very strongly the fact that before a hearing of this sort, operated this way, in the length of time that is allowed for presentation and discussion, a problem of that sort, and many, many other problems could not possibly be answered satisfactorily, or stated satisfactorily. There are too many facets,

too many facts, too many things that would have to be gone into.

Statement¹ of

DR. GILSON COLBY ENGEL

Professor of Clinical Surgery

University of Pennsylvania

Associate Professor of Surgery

Jefferson Medical College

Philadelphia, Pa.

I am a past president of the Medical Society of the state of Pennsylvania and am also president of the Pennsylvania Health Council, which is composed of 46 member organizations representing lay, professional and consumer groups interested in health, and in that capacity address this hearing.

The state level is a broader field and can support a state health administration in carrying out its program as we are doing in Pennsylvania.

The National Health Council can cover a vast number of national projects; basically, at present one job is for them to create state and local health councils to help in that area of health problems.

As long as there are needs to improve health, there are needs for health councils at all national, state and county levels.

APHA Health Survey

Health in Pennsylvania has for many years been the concern of the medical profession and of lay groups interested in health. At the request of the medical society of the state of Pennsylvania our previous Governor, now Senator James Duff, had a health survey done by the American Public Health Association on health needs in Pennsylvania. Specific recommendations came out of this survey which required the changing of laws to set up a merit system and to legalize the creation of local health units.

The first objective of the Medical Society and the Pennsylvania Health Council was to get the support of the newly elected Governor John Fine to be sympathetic to these changes. He had committed himself to these ideals and created a committee composed of the President of the Medical Society of the State of Pennsylvania, a prominent layman, and myself, as President of the Pennsylvania Health Council, to make recommendations

to him for a man to be appointed the new Secretary of Health. We recommended a man who was trained and well qualified in public health with years of experience behind him. He came from the United States Public Health Service, and this man, Dr. Russell Teague, was appointed by the Governor as Secretary of Health of the Commonwealth.

Advisory Health Board Created

The Governor supported legislation which was passed creating an Advisory Health Board composed of five doctors of medicine, two laymen, one sanitary engineer, one dentist, and one pharmacist. I happen to be a member of this Advisory Health Board.

The legislation also created a merit system for employees of the Department of Health to insure tenure of office and advancement in rank depending on qualifications.

It also gave permissive legislation to create local public health units in areas which were desirous of so doing.

At present the Advisory Health Board has just completed working out a merit system which will cover a large number of key employees in the Department of Health and place them under Civil Service.

We are trying to bring in a well qualified man as the Deputy Secretary of Health and are recommending the creation of three Assistants to the secretary, one to be in charge of local health services, under which would be regional offices, district offices, municipal health departments and county health departments; another to be in charge of preventive services, under which would be maternal and child health, chronic disease and accident prevention, dental health, communicable disease control and tuberculosis control; and the third to be in charge of environmental health services, under which would be industrial hygiene, sanitation and sanitary engineering. This will strengthen the general organization of the Department.

Health Services

We have also set up the geographic pattern for locations for local health units, the size of local health units to be 100,000 population, and, at present, the creation of a local health unit in Butler County. We are constantly urging communities to create these units.

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

Mental health and hospitals in the Commonwealth should be transferred from the Department of Welfare to the Department of Health so that all health matters, including the important mental health, come under a Health Department.

Personally, I believe strongly that Health Departments and their personnel should be divorced from political control. Politics has no place in public health. When politics takes over health matters, only waste, inefficiency and deterioration of standards appear in the picture. There is less chance in a smaller unit for this to happen. The larger the control and the greater the number of units involved, the greater the chance for political control, drones, inefficiency, and waste. The department becomes purely political.

I have advocated for some years the removal of health services at the national level from the Federal Security Administration and the creation of a Health Administration headed by a Secretary of Health to be of Cabinet status, and this Secretary to be a Doctor of Medicine. Under this Secretary to be placed all health matters such as health units, hospitals, health education (lay), maternal and child welfare, and so forth. A number of deputy secretaries would be created in charge of different services.

As an example, one in charge of military medicine, one for civil medicine, one for hospitals, one for veterans' medicine, and so forth. If such a plan were followed it would set an efficient pattern at the Federal level.

The most important part of all health programs is decentralization to the local level. It is only when this is done that real efficiency takes place and the public gets real service. Our object in Pennsylvania is to decentralize our health services to the local level in creating local health units, with power and control at that local level. When the public in a local community becomes interested in and have control of its health problems only then do you have the real Utopia we hope for.

Health Insurance

As to the cost of medical care in the Commonwealth of Pennsylvania, our citizens are covered by five Blue Cross plans, the Intercounty plan and commercial carriers against hospital costs, which have been rising because of increased food costs, increased labor cost, reduction to a 48- and now a 40-hour week and increased cost of equipment, all of which becomes increasingly more severe as our

inflation trend continues to spiral upward. This the Federal government and the planning economists could do something about if they had the courage.

At present the population of the Commonwealth of Pennsylvania is 10,498,012. Of this group 8,221,000 are covered in voluntary plans to protect them against the cost of hospitalization. This represents 78.4 percent of the population, broken down as follows:

	<i>Total</i>	<i>Percent</i>
Five Blue Cross Plans.....	4,640,050	42.2
Intercounty Plan.....	200,000	2.0
Group Commercial Insurance.....	3,380,950	32.2
Total.....	8,221,000	78.4

We also have in Pennsylvania one of the outstanding Blue Shield plans—Medical Service Association of Pennsylvania—which is statewide in its activity and is rapidly growing in its membership and scope. At present this plan has 6,650,000 contracts as follows:

	<i>Total</i>	<i>Percent</i>
Surgical.....	4,726,000	45.2 population.
Medical.....	1,924,000	18.3 population.

This plan is younger in years than Blue Cross but is enjoying very vigorous growth.

A general plan for improvement of health services in Pennsylvania is being followed and is gradually shaping up, which will give this commonwealth something in health to be proud of.

All we need is the continued help of the political groups at Federal, State and County level to keep political interests out of health.

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Secretary of Health

Commissioner ALBERT J. HAYES. In connection with your expressed view that possibly a Government post of Secretary of Health, with his assistants, might better take over the Federal government's health program, I cannot help but ask your opinion as to whether or not this might also be political.

DR. ENGEL. You already have—when I speak of political I am speaking chiefly of political patronage, where a man has to be cleared politically before he gets a job in the health department. That is not my idea of setting good standards. You already have a United States Public Health Service which is excellent.

We went to that service to get our Secretary of Health. I am not opposed to that. We would like

to take the medical stuff out of the Federal Security Administration, where it does not belong, and put it under somebody who understands and has been trained in health to run it. Look at the efficiency in your services, to answer your question. You have three services, your Navy, Marine medicine, which comes under Navy, and Army. If you could now unify the whole group and then if your Army were suddenly called upon—a big strain, lot of casualties—needed help, then you could pull your men from other services to fill in. At the present time men sit and loaf on some services while other services are being worked to death.

It would unify that.

Commissioner HAYES. Dr. Engel, I am not disagreeing with you at all, but you did mention politics and you did mention patronage.

Dr. ENGEL. That is right.

Commissioner HAYES. I think that we must assume under our political system when an administration changes—certainly the cabinet members change with the administration—and many people have called that politics and have called that patronage. I was wondering whether you gave that consideration in recommending a Secretary of Health.

Dr. ENGEL. Yes, because I think eventually it would work out just as the secretary of health in a lot of the states of the country when they have gone on—Massachusetts for example—through Republican and Democratic Administrations. If you get a good man and the people want him to stay there, the other administration which comes and takes over will not throw him out. That is a proven fact in states in the United States.

DENTISTS ON ORAL HEALTH

Statement¹ of

DR. E. A. BRANCH

North Carolina State Board of Health

We are going to admit that we need more dentists and better dental care. But in a recent survey by the American Dental Association, based on the 1950 census, there were 1,020 dentists in North Carolina serving a population of a little over 4,000,000 people, or about one to 4,000. We can take out the 5 percent who, by good fortune of nature, do not need any dental care, babies who have no teeth, and folks like that, and bring it down to about 3,600.

Now, these figures for the State as a whole do not take into consideration the uneven distribution of dentists, the victims of which are the very groups that we are considering today.

Low Proportion of Negro Dentists

Now, this distribution in North Carolina will vary from one dentist to 2,000 in one county to one dentist to 18,000 in another county. And there are nine counties in the State, sparsely settled, without a single dentist. Another distribution factor which must be taken into consideration is the proportionately smaller number of Negro dentists.

Now, the Negro dentist-population ratio is approximately one to 12,000. The fact has to be recognized that the distribution of dentists is highly correlated with the economic and cultural conditions of the population. It should be pointed out, however, that the relation between the per capita number of dentists and the population per square mile is not as significant as it might seem, due to improved transportation. The people in most of these nine counties are in reach of dental services in places which they frequent for business and amusement purposes.

Now, in regard to dental conditions, North Carolina and the other Southern states occupy approximately a middle position. The Southwestern states have a lower prevalence of dental defects due, it is believed, to the more widespread presence of naturally borne fluorides in the water, while the Middle Atlantic, New England and Northwestern States have a higher prevalence. But, even so, surveys show that approximately 5 percent of our children of elementary school age need dental attention.

Unmet Dental Needs Recognized

Now, among the first to recognize and show a real concern over the unmet dental needs were the organized dentists of North Carolina. As far back as 1918, the North Carolina Dental Society recommended that dentistry be included in the

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

public health programs of the State, and ever since that time the dentists of the State have endorsed, supported and promoted many measures for meeting the dental needs of the people.

This leads to a more optimistic viewpoint of the situation and calls for a progress report. Decided progress is being made in reducing the gap between the availability and the need of dental service. This is being accomplished by attacking the problem at both ends, by increasing the number of dentists and by reducing the need.

The founding of the Dental School at the University of North Carolina is of great significance and promise in meeting the need for more dentists. Congratulations and gratitude are due to the members of the Dental Society for sponsoring and helping to bring to fulfillment its establishment. And may I say that the first Dental College Committee appointed by the organized dentists in this State was in 1921.

Beginning with the graduation of the first class in 1954, we can expect a yearly increase over the present of from 40 to 50 in number of young men and women joining the ranks of the dental profession. In a few years' time, this will be an appreciable gain in the number of dentists, and will help to equalize the distribution.

New Dentists for Rural Areas

With the largest cities and towns now fairly well balanced as to supply and demand, the new dentists will be going more and more into the smaller towns and rural areas. We would like to see an increase of at least ten Negro dentists each year. This suggested number is small for two reasons. The prevalence of dental defects is less among the Negro population than among the white; and the demand for dental service is also less.

It must be remembered that need and demand are not synonymous; that the demand does not keep up with the need. Now, this brings us to the problem of reducing the need.

Fluoridation Measures

Thanks to dental research, effective measures have been found for the prevention of dental caries. Fluoridation is the most spectacular of these. Here again the North Carolina Dental Society has led in advocating the adoption by the

municipalities of this preventive procedure, which, by restoring to the water in the proper proportion a nutritional element, reduces the incidence of tooth decay.

At present four municipalities are fluoridating the water supply, while 14 other towns are in the process of installing the necessary equipment; these cities and towns have a combined population of 625,000. Fluoridation may not benefit to an appreciable degree the dental health of the groups to which we are giving priority in today's planning.

Now, in time it might benefit them indirectly by releasing to them more dental service. For children in rural areas, the topical application of sodium fluoride to the teeth is recommended. Fortunately, there is yet another effective defense measure. That is dental education, as to proper home care, diet controls, and the value of early and regular professional care.

Brushing Teeth After Eating

Research studies in the field confirm and reinforce the contention that great benefits are to be derived from brushing the teeth as soon after eating as possible, and from temperance in the consumption of carbohydrates. These are relatively simple practices which can be acquired by every individual.

Now, too much emphasis cannot be placed on the fact that good dental health depends largely upon the individual acceptance of personal responsibility. Of course, it is our duty to educate people to appreciate good dental health and to know these protective measures. But we should not waste too much sympathy on those who are not living up to the light.

Now, the individual, of course, cannot always be held responsible in regard to the matter of diet and dental service. Both of these are dependent on economic conditions. A family on a tobacco farm, with no garden and no milk cows, cannot provide a balanced, protective diet for the children. In the rural Negro tenant farmer group, there are many who cannot afford dental service.

Concentrating Efforts in Young Children

As we see it, we must increase our educational efforts and activities, and insofar as possible provide for the early detection and correction of

dental defects for the underprivileged. It is generally agreed that, with limited resources as to personnel, concentrating our efforts in the early school age group will yield the greatest returns. This will call for more dentists who will specialize in dentistry for children.

The progress being made in the dental health education in the classroom is gratifying, and it is bringing good results. Of course, there is a crying need for more public health dentists to go into schools. Funds are available for their employment, but public health salaries cannot compete with the incomes of dentists in private practice and are not commensurate with the high costs of dental education.

Dental Student Assistance

We believe a substantial loan fund for dental students would help to fill the need for more dentists in public health and in the rural areas. The public health dentist, trained in children's dentistry and in child psychology, can go into the school and teach mouth health didactically and through demonstration. By his very presence in the school—just being there—through each step of his procedure, by making friends with the children in the classrooms, inspecting the mouths of all the children, referring the privileged children to the family dentist and making the necessary dental correction for the underprivileged, there is educational value.

Of course, the children who receive the dental corrections are greatly benefited, but during the past, the number worked on by the school dentists in North Carolina has been only 61,814. Inasmuch as there are not enough school dentists to meet the need, the dentists in private practice are cooperating by working for underprivileged children on an hourly basis at a financial concession. I want you folks to get that now. That is what the dentists in private practice are doing.

The situation, then, is that the need for dentists and dental services can be met by increasing gradually the number of dentists, by reducing the dental health needs through fluoridation of the water supplies, by topical application of sodium fluoride, through more intensive and widespread dental health education, and through the increased emphasis on dental care for children.

Statement¹ of

DR. WILLARD OGLE

Secretary

Texas State Dental Society

The public has been exposed to an excess of misinformation relating to facts and fallacies of dental health. This has fostered public apathy to dental health problems, manifest by a lack of appreciation of the value and the importance of dental health in relationship to general health program. The development in recent years of more effective procedure in the prevention and control of dental caries has greatly increased public interest in every area of oral health.

Dental health needs are primarily individual and community problems, beginning with the very young inhabitants, and attaining a high range of occurrence with advancing years. The ratio of dental defects at any given time add up to a staggering total. The prevailing proportion remains high due to the bulk of new defects occurring each year.

Availability of Dental Service

The relative extent of dental needs is dependent in a large measure upon the availability of dental services. The dental profession of this particular region has long been aware of the maldistribution of dental personnel. This may be ascribable, fundamentally, to the nature and volume of dental disease, the habits and attitudes of the people, and their willingness and ability to pay for dental care. The old law of supply and demand exerts motivating influence.

A practical evaluation of required dental personnel cannot be made solely on the premise that dental care should be available to all persons who are in need of such care. There is a disparity between the potential need for dental services and the amount actually procured, due more to insufficient demand than to inadequate dental facilities. The actual demand for dental care cannot be determined from available data. Plans to provide dental personnel to meet the over-all need for dental services for all people is not practical.

Where free dental service has been maintained for indigents, it has been exceedingly difficult at times to influence many such individuals to take

¹ Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

advantage of such. There is often evidence of effort to avoid or evade such benefits. Any long range plan to increase greatly dental personnel in the next few years will of itself create an unemployment problem for the dental profession, for the evidence points to material reduction in such needs through preventive treatments.

Demand for Dental Services Increasing

We do know that the effective or actual demand for dental services is increasing. We also know that the dental profession is slowly but surely expanding its scope of service through an increase in professional personnel and auxiliary aids. We further know that dental personnel is available in some localities where the demand is low, in fact, insufficient to make a dental practice profitable; while in other communities there is evidence of greater demand, but not dental personnel available.

Concentration in Larger Centers

There is definitely a concentration of dentists in the larger centers of population, and evidence of reluctance by dentists to locate in the smaller communities. A continuous effort has been made to influence dental graduates in favor of locating in the smaller communities without much success. Facts prove that the dentists locating in smaller communities become established in practice much earlier than those locating in the larger centers of population.

The ratio of population per dentist in the Northeast section of Texas is 3,312; for the Southeast section, 2,889; the Northwest section, 1,509; the Southwest section, 3,925. New Mexico, 3,914; Oklahoma, 2,893; Arkansas, 4,195; Colorado, 1,713; Louisiana, 2,614.

There are 2,684 licensed doctors of dentistry in Texas. Some 41 are retired and an equal number are employed full time in various institutions, with the balance in private practice, with an approximate average of 3,197 persons per dentist.

The Armed Forces desire a ratio of 2 dentists per 1,000 military personnel. Their current ratio is 1.7 dentists per 1,000 personnel, and evidence indicates health standards for military can be maintained at this level.

To apply the military ratio to Texas population, we would require some 11,000 additional dentists, and many would be unable to maintain a practice. Dental services have been provided for the majority of communities having adequate actual de-

mand for such. The future expansion of dentistry will be reflected in the smaller communities.

Doctors of dentistry concentrate in areas of high per capita income that provide cultural and educational advantages and greater opportunities for a lucrative practice. The concentration of doctors of dentistry in the larger centers of population is not as serious as formerly, due to improved transportation facilities.

Pronounced Shortage of Negro Dentists

There is a pronounced shortage of Negro dentists. Of the 254 counties in Texas, 139 counties have no Negro dentist. Three of these counties, however, have no Negro population, and some have less than 100. On the other hand, three counties—Ellis, Hill, and Navarro—with a Negro population of 34,947, have only one Negro dentist. Bowie County with a Negro population of 20,000 has two Negro dentists. Anderson County, with Negro population of 14,000, has one Negro dentist. Gregg County, with a Negro population of 11,796, has no Negro dentist.

More than 50 percent of the dentists of Texas are in the 41-65 age group. Thirty-seven percent are 21 to 40 years of age, and 6.5 percent are over age 65. Average age, 46.05.

In Texas 64.1 percent of the dentists are Texas graduates. All practicing dentists in Texas have either a doctor of dentistry degree or doctor of dental medicine degree; 21 percent have earned some type of bachelor's degree, 2.5 percent have masters degrees.

Dental Needs

That we may comply with time limitations, permit us to enumerate a few of the more important dental health needs:

- (1) More planning with other people than for other people.
- (2) Improved distribution of dental personnel.
- (3) Expanded facilities for educating dental personnel, especially in the field of preventive dentistry and dentistry for children.
- (4) Increased dental services for children, with attention to special need for handicapped children.
- (5) New sources of funds for dental research.
- (6) Dissemination of authentic information regarding fluoridation procedure.
- (7) Adequate dental services for State institutions. This is urgent.
- (8) Increased funds for operational procedures of Divisions of Dental Health, State Departments

of Health, with opportunity to increase salaries for necessary personnel. The current budget is inadequate.

(9) Increased number of qualified ancillary aids.

(10) More adequate and nourishing snack items for sale in public schools, such as fruits and fruit juices, popcorn, and foods less favorable to caries susceptibility.

(11) Increased dental facilities and staffs in hospitals.

(12) Mobile dental units for those rural areas without dental services.

(13) More voluntary pre- and post-payment plans.

(14) Further education of the public against the evils of government control

(15) Community support of dental services where such support formerly has been inadequate for dental practice to be maintained.

Studies made by the Texas State Dental Society indicate commensurate dental personnel in the metropolitan areas to meet the existing or realistic demand for dental care; while revealing a degree of insufficiency of dental personnel in certain rural and smaller centers of population, especially where the inherent capacity for development of a dental practice is, to all practical purposes, decidedly unproductive.

Statement¹ of

DR. DAVID W. BROCK

Chairman of Council on Dental Health and President-elect

Missouri State Dental Association

St. Louis, Mo.

The following report constitutes an evaluation of the dental health situation in Missouri, based upon available data, and conforms, as nearly as possible, to the areas of investigation suggested by President Truman. The interpretation of this report depends upon an understanding of the nature of dental diseases, their prevention, control and treatment, as preliminary to any discussion involving an appraisal of dental care and personnel involved.

Dental diseases are probably the most prevalent of all afflictions of mankind and are unique in that they do not tend to spontaneous cure but require

services of those skilled in the science and art of dentistry. Unattended, the conditions become progressively worse and ultimately cause the loss of all of the teeth, in addition to such illnesses as are the result of associated pain, infections, malnutrition, defects in speech and hearing, local irritation, and their various sequelae including social dislocations.

Tooth decay is most prevalent in childhood years and youth. Diseases of the gums and supporting tissues occur later in life; many times caused by earlier neglect. It is well known that the average adult bears evidence to the presence of dental defects that have accumulated during all or part of his lifetime. Timely attention would have prevented and controlled most of these conditions.

Child Dental Health Most Important

Since there is such an accumulation of dental defects in the mouths of the adult population and since the majority of people do not seek regular dental care, but continue without it until they reach an edentulous age, the dental profession has come to the conclusion that the dental health of children is most important and that in all programs of dental health education, prevention, control and dental care, children should receive priority.

Children's teeth decay at an early age; hence, dental health programs for children should begin at the age of three and should continue through the primary and secondary school years. Provision for dental care during those early years will insure the teeth of the adult population and emphasize their value as a lifetime asset.

We may summarize by saying that good dental health is fundamental to good general health; neglect of mouth health has permitted a great deal of dental needs to accumulate, and that dental disease should be prevented, controlled and corrected from the age of three.

Measures To Prevent Decay

Although no one agent has been discovered that will completely prevent tooth decay, certain agents and practices have been demonstrated to be effective in reducing its prevalence by as much as 65 to 70 percent. Improper diet is a factor in tooth decay. The substitution of confections and sweetened beverages for wholesome foods and drinks serves to deprive the body of needed health-building foods and increases the activity of the

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

tooth-decay process in the mouth. Tooth brushing, correctly performed immediately after each meal, cleans from the teeth the adhesive food residue which permits acid-forming bacteria to multiply and produce cavities in the teeth.

Controlled fluoridation of community water supplies has been demonstrated to reduce tooth decay as much as 65 percent. Tooth decay can be controlled, and affected teeth restored and made serviceable for an indefinite number of years by regular visits to the dental office. The total reduction in dental needs, if these simple and inexpensive methods are employed, is beyond computation.

Challenge of Available Methods

The challenge offered by presently available methods of controlling tooth decay has not been accepted by the people. It is largely a matter of health education, not only in regard to personal habits but in regard to a community approach. This is well demonstrated in Missouri.

Two years ago the American Dental Association, following the announcement of the Public Health Service, indorsed controlled fluoridation. The dental profession in the State launched a vigorous campaign for this, the best dental public health buy of the century. Community lethargy and minority opposition have frustrated all fluoridation projects and at the present time Missouri is one of the three States that have no fluoridation programs. For two years Missouri children have been denied its benefits although controlled fluoridation has been indorsed by all leading national health organizations.

Future Dental Personnel Needs

The future need for dental personnel will be entirely dependent upon the employment of known control measures. Their utilization will produce demonstrable results within 5 years. In the meantime, Missouri, with free dental schools, will continue to receive the services of a steadily increasing number of dentists.

The dental schools presently foster research projects. At the present time there is one dentist for each 1,579 persons or a more favorable ratio than the national ratio of one dentist for each 1,777 persons. Apparently, there is a scarcity of dental personnel in certain rural areas. This cannot be taken too seriously, however, since modern transportation facilities relieve the situation.

There are a few areas that might be helped by educational and transportable clinical facilities under the supervision of the Division of Health. Scarcely any incorporated area is without some type of a dental program. These programs have gradually expanded over a period of years and promise to continue a healthy growth. All of the larger communities have comprehensive programs including dental health education and dental care for children of low-income families and indigents.

Clinical Facilities

Clinical facilities vary in different communities although services for children of low-income and indigent families are generally available—sometimes in the private dental office. In St. Louis and Kansas City, well equipped clinics are in use, to which children are referred from the public and private schools. Three clinics are operated by the dental schools, two in St. Louis and one in Kansas City. Five clinics are operated by the Division of Health in rural communities. A modern health center clinic and a school clinic have been established in St. Louis County for a number of years.

The number of people who seek dental care and their ability to afford such care are not too intimately related, because of the catastrophic nature of dental diseases and their predictability. Dental care is most frequently a matter of appreciation of its advantages. This has been demonstrated many times by the difficulties involved in maintaining attendance at children's free clinics during the summer months when the children prefer recreation to health services. It has also been demonstrated in adult free clinics where frequently the patient refuses to return for further treatment after his discomfort has been relieved.

Increased Health Education

Increased health education may insure that health services will be included in many more budgets. The predictability of the need for dental care and the amount of care would seem to reduce its attractiveness in prepayment insurance programs. Such programs for children might become popular, however, if beneficiaries were enrolled at the age of three and incremental care was continued without interruption through the age of eighteen. The postpayment plan seems to be the most successful and popular. Dentists have been using such plans individually for years and two such plans are operating in Missouri with association indorsement.

Efficient and adequate operation of dental health programs at the State and community levels depends upon adequate funds. Probably no comparable activity in the health services is allocated less of the division budget than the dental program. Pelton reported $\frac{6}{100}$ of 1 percent of all expenditures for health from all sources went into dental programs in 1945. During the year 1950, dental health programs received but $\frac{4}{10}$ of 1 percent of the Public Health Service grants to the States. Even with matched funds from the State, the amount allocated is bound to be inadequate to the problem.

The dental problem today is universal. The best official approach is one in which health education predominates. It would seem then that adequate funds should be provided by the State or, if need be, as ear-marked funds from Federal sources to provide for an active dental health education program to extend from the State level to the community level. Such a program should be coordinated with the department of education. Fluoridation should be effected immediately where feasible.

Statement¹ of

DR. FREDERICK HERBINE

President

Pennsylvania State Dental Society

It is well to bear in mind in any discussion of dentistry and health needs that of all the afflictions that beset mankind, dental disease is the most common. Here in Pennsylvania as high as 95 percent of our people are somehow affected, the most common way, of course, being by dental decay. Also, decayed teeth do not heal themselves and in most cases the uncared for mouth will become progressively worse, resulting in a breaking down of the chewing process with its accompanying ill effect on one's general health. This being so, the dental profession has come to the view that more and more emphasis must be put upon the prevention of dental decay and upon the early care of decayed teeth, especially in children.

As this opinion gained support and as various agencies interested in dental health began to expand their programs, a shortage of dentists naturally developed in some areas. I make specific mention of some areas because we believe that mal-

distribution of dentists is a more important factor adversely affecting the availability of dental health care than an over-all shortage. The obvious answer to a shortage of dentists seems to be to produce more dentists and our dental schools are doing this at a capacity rate, being encouraged and aided by the State, private donors and the dental profession itself.

While we are in complete sympathy with this program for the training of more dentists, it is certainly not my intention to convey the impression that we believe this to be the entire answer to the assumed shortage.

Reduction of Dental Decay

A much more productive course seems to us to be to cut down the demand for dental care by reducing the rate of dental decay. Fortunately, there are reasons to believe that this can be done, through increased emphasis on dental education, increased emphasis on dentistry for children, and the continuance of a vigorous program to bring about the controlled fluoridation of public water supplies. Many agencies agree with the dental profession on these points and effective programs are already under way, some of them producing measurable results.

... Organized dentistry everywhere, from the American Dental Association down through the State and local societies have endorsed and are vigorously fighting for enabling legislation to bring about universal controlled fluoridation programs. The medical profession and many interested lay groups have also been most helpful in this venture.

In the dental schools of Pennsylvania, individual practitioners and some pharmaceutical firms are conducting dental research programs. It is our belief that private, State and Federal funds made available to educational institutions to further dental research represent a sound investment in dental health. Although it is obvious that existing programs could be expanded, it would seem that this field of endeavor is getting adequate attention in Pennsylvania.

Dental Department Lack of Planning

Dental surgical care in the hospitals of Pennsylvania is available to meet the needs, but lack of planning for dental department space and facilities is frequently evident, especially in the older buildings. State-aided clinics are filling a real need in the field of dentistry for children, and this

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

program should be expanded through the making of more funds available to the Bureau of Dental Health.

This present policy of granting State aid to local community efforts, rather than the establishment of clinics wholly supported by State or Federal funds, should be encouraged. There is ample evidence that communities are willing to accept the prime responsibility for the establishment of dental clinics, but it is also clear that some communities require additional financial help to get the programs under way or during periods of economic stress.

Indications are that general dentistry is required by so many persons that it has become an uninsurable item, so to speak, because the theory of spreading the loss does not work. With dental surgery, however, insurance programs have been effective in our State. The Medical Service Association of Pennsylvania operates a program under which certain hospital dental care is available to its policy holders, and the success of this voluntary plan seems to indicate a major contribution is being made toward the care for dental needs of a catastrophic nature.

Local Level of Effectiveness

We believe that effective dental care programs must be on a local level with community understanding and support. Dental health education programs should be encouraged and supported by the State in the same way that all education is assisted by the State. It would seem that Federal funds should not be required in these two most important fields of endeavor but that Federal aid to educational institutions training dentists and to those institutions conducting dental research in dental health is desirable.

* * * * *

Commissioner ALBERT J. HAYES. Dr. Herbine, I wonder whether you would care to express your views for the benefit of the Commission with reference to the problem of getting dentists and dental clinics established in the low wage, rural and agricultural areas and in the remote areas of our country?

Dr. HERBINE. We are doing that—rather, the State Department of Health is doing that in the rural areas by State-aided clinics. The local community will establish the clinic—that is, the physical facilities for the clinic—and the State will pay for the clinician's time up to 15 hours a month.

Mobile Units

At the present time they (State Department of Health) are also thinking of establishing mobile units to go into the areas where they do not have large enough population to support the dentist's practice.

Commissioner HAYES. Would you care to elaborate on this mobile unit more? Who will finance the mobile unit?

Dr. HERBINE. State Department of Health.

Commissioner HAYES. I see.

Dr. HERBINE. That is in the blueprint stage at the present time. It was brought up about 2 years ago. The government has taken all the mobile units that were being put out.

I also believe that there have been some private institutions—private money—that would buy some of these units, mobile units.

Commissioner HAYES. From testimony already submitted to the Commission from members who have served on panels, it appears that we have a rather acute problem in the rural and remote areas of the South and the Middle West. Would you say that the arrangement that you speak of that is workable in this general area might also work out satisfactorily in those areas?

Dr. HERBINE. I think it would work out very well, because if you realize if you take some of the counties in Pennsylvania where you might have 2,500 people within the whole county, the county might be 20 miles long and 25 miles wide, and it is very sparsely settled; then it might be more economic for the individual person to go to a dentist in another city or town, and naturally that area would not support a dentist; but for a program such as this I think a mobile unit for children especially would work very well.

I think that would work the same way regardless of where it was, either in the Midwest or in the South, because you would be bringing the service directly to the people. It seems that a lot of the trouble has been that it is not that these people cannot afford dental attention, but, you take a farmer working on a farm, he is working every day and he just does not have the time to take his children to the nearest town to have dentistry done.

In our rural areas, at least those that I am acquainted with, a lot of the dentists start to work at noontime and work until 10 or 11 o'clock—they do not work in the mornings for the simple reason that the farmers can only come in and bring their

children in the evening when it gets dark. That will take care of some of that load, too.

Statement¹ by

DR. JOHN B. BENEDIKTSON

President

California State Dental Association

San Francisco, Calif.

To understand properly the problem of dental health, the Commission should know that extended surveys have proved beyond all doubt that 95 percent of the population experience dental caries. According to reliable estimates, there are 10,648,000 people in California. Probably only one-fourth of that number actually demand dental treatment and we believe that demand is met. We can assume that one-fifth of the total population are children below the age of 18 and, taking the survey made in one of our urban areas and judging from other surveys throughout the State, these children will average approximately seven decayed-missing-filled (DMF) teeth per child. At any given time at least 60 percent of the total number of children need immediate dental care.

Progress of Tooth Decay Rapid

As children increase in age so does the incidence of dental caries. The average 15-year-old in the urban district previously mentioned had 10-plus DMF teeth.

Tooth loss develops rapidly and at age 20 years approximately 25 percent of that age group will require a bridge of one or more units. Tooth loss continues at a fairly constant rate and at age 40 years, 30 percent of the population will need full dentures. At age 60 years the need for dentures will have doubled.

We know that tooth decay progresses at approximately one tooth per person per year, from the time people get their teeth until they lose them. Many research studies have shown that dental caries is progressing about six times faster than dentistry can repair the damage. For this reason, as well as for the ethical obligation to improve the public health, the dental profession has strongly emphasized the importance of preventing, as well as repairing, tooth decay.

We also have the problem of peridontal disease. Research studies indicate this is on the increase.

The profession is attempting to find some way to measure the prevalence of such disease in the population and to find a means of mass treatment and prevention. We also have the problem of malocclusion. Roughly, that gives a picture of dental need.

Supply of Dentists

At the present time there are approximately 7,275 licensed dentists in the State of California. That does not mean there are that many practicing. From that figure should be deducted those who have retired but who maintain their licenses. Today, we have less than 7,000 practicing dentists attempting to take care of over 10,500,000 people in California.

The problem of dental care of the people today is dependent upon an adequate supply of dentists. The demand for dental care has been the result of education by the dental profession, pointing out the advantage of having dental care rendered when first needed. The number of dentists required will be reduced in direct proportion to the success of our dental health education activities.

Measures To Meet Needs

There are three means which can and should be employed in an effort to meet the dental health needs of this State and the Nation. Briefly, they are:

1. More equitable use of dental manpower by the Armed Forces.
2. A greater prevention campaign.
3. Greatly extended dental research.

Waste of Dental Manpower

Present standards in the Armed Forces call for one dentist for each 500 persons. This is compared to the national ratio of one dentist for each 1,777 persons.

The military ratio is interesting. Why these men who have been selected because of their above average fitness should require almost four times as many dentists as do the balance of our citizens, including children, adults, and aging dentally-degenerating people, is hard to understand. We could not quarrel with the military plan if we were convinced the services of that number of dentists were needed and were utilized.

We have adequate testimony to the fact that during World War II, many dentists served in nondental capacities such as recreational directors, purchasing agents, construction superin-

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

tendents, etc. We are informed by dentists in the Armed Forces that there is presently a like waste of dental manpower.

There are only 45,000 dentists in the United States under 51 years of age. There are 33,000 dentists 51 years of age or over, plus 4,000 licensed dentists who do not practice, or a total of 82,000 licensed dentists. This approximates one dentist to each 1,777 persons.

Dental colleges are not able to materially expand their teaching facilities or their teaching staffs. They, too, have been hard hit by demands of the military. Their finances will not permit material expansion. It takes a minimum of six years to adequately train a dentist.

We cannot expect a great influx into the profession. This can only mean we must make every use of those who are trained, and employ every possible means of reducing the incidence of dental disease through prevention and research. The latter will not only help the civilian population, but will have a like effect upon those in military service.

Steps in Prevention

There are three important steps in prevention:

1. Diet, or reduced intake of highly refined carbohydrates.
2. Better mouth hygiene.
3. Fluoridation of communal water supplies.

The first, diet, can be effective only if people can be induced to eliminate from their diets those things which they seem to enjoy. This must of necessity be an individual measure and therefore has little likelihood of universal appeal or of great numbers of people adopting it.

The second, improved mouth hygiene, is also an individual measure, which requires brushing the teeth immediately following the intake of food, and periodic prophylaxis. A recent survey showed that over one-third of the Nation's population do not even own a tooth brush.

The third preventive measure, fluoridation, is a safe, proved, effective procedure, one that extended scientific research has shown to be the most dynamic means yet known to reduce the incidence of dental caries.

The Federal government should assist States in the installation of fluoridation equipment in those areas where the communal water supply is fluoride deficient. It can further assist in a continuation or even an expansion of its activities

in informing the public of the safety, the economy, and the benefits of fluoridation.

It is interesting to note that for many years members of the dental profession have reached down into their individual pockets and contributed practically every dollar used for all forms of dental research. The amount of money contributed by the Federal government, or any of the subdivisions of government, has been infinitesimal. Dental research literally has been starving for money. While it is true that in 1949 Congress authorized the establishment of the Institute of Dental Research, to be constructed at Bethesda, Md., it has failed to provide funds to construct the building and to carry on any research in that institution.

Recommendations for Adequate Care

If our civilian population is to have adequate dental care, we must make these recommendations:

1. Undertake a Nation-wide campaign to reduce the excessive use of highly refined carbohydrates.
2. Step up grants for dental research.
3. Assist dental colleges in their problems.
4. Prevent the civilian population from again being denied dental treatment due to lack of manpower as in World War II.
5. Restrict military forces to a number of dentists more in proportion to that of civilians—possibly 1 per 1,000.
6. Reduce decay by two-thirds in the future by immediately fluoridating every communal water supply in the United States that is fluoride-deficient. The dental profession has already given its wholehearted endorsement to this vital public health measure.

Aid to Dental Schools

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Commissioner RUSSEL V. LEE. I have a couple of questions about aid to dental schools. Do dental tuitions pay the costs of dental education?

Dr. BENEDIKTSON. No, they do not.

Commissioner LEE. What makes the difference?

Dr. BENEDIKTSON. The State government, as in California, for instance, supports the difference. That is a cost borne by the people of California.

Commissioner LEE. Do you think there should be Federal aid to dental schools?

Dr. BENEDIKTSON. The AMD feels that there should be more aid given.

Commissioner LEE. By what agency?

Dr. BENEDIKTSON. By the Federal government, or even by the States.

Statement¹ by

DR. HUGO M. KULSTAD

**Representing the Southern California
State Dental Association**

Dental diseases are universal in California, as they are in the rest of the Nation, and according to evidence reported from well conducted studies, are on the increase.

This seems illogical since the dental profession now has sufficient knowledge on the control and prevention of these diseases to practically wipe them out. In no other health problem is there such lack of interest on the part of the public in assuming responsibility for control and prevention.

While the dental profession has been recommending control and prevention, the public seems interested principally in repair programs. Such programs are impracticable, with the present disease rate, and financially unsound as well as impossible of realization.

The dental profession has recognized the inevitable lag between making knowledge available and its effective utilization, and has advocated increasing the number of qualified personnel, both professional and auxiliary. California is fortunate in having three dental schools, with a fourth one building. We now graduate 17 percent of the dentists in the United States and have only about 10 percent of the population. Our dentist-population ratio is one to between 1,300 and 1,400 individuals, while the national average is one to 1,777.

* * * * *

Programs Lag Behind Available Knowledge

Dental research has made rapid progress here in California as it has in the rest of the United States. Many new methods and materials for the treatment of dental diseases have been found and are in use in the dental offices throughout the State. In addition, new and improved methods of prevention and control have been discovered. These include the control of the intake of ferment-

able starches and sweets, the improved methods of mouth hygiene, and the use of fluorides both in direct topical application to the teeth of children and through the balancing of fluorides in community water supplies.

The acceptance and use of these programs, as has been stated, lags far behind the available knowledge.

Facilities for the care of the needy children of the State are being expanded through services in private offices, dental clinics and hospitals. Lack of public interest in supplying adequate funds limits the extent of such services. Less than 1 percent of public health monies spent go to support dental programs.

Few families could be classed as unable to afford necessary dental care if they accepted their own responsibility for known control and prevention available to them. These simple programs of better eating through selection of nutritious foods instead of injurious desserts, confections, and sweetened drinks, and properly cleaning the mouth would cost no more than is now being spent and would eliminate dental repair costs.

"As long as the population insists on doing nothing about prevention of dental disease, insurance programs, either private or government, will not solve the financing of dental care. The premium rates would be prohibitive even for middle income families. The experiences in this field in some foreign countries have proved this statement.

Stepped-Up Health Education Necessary

Effective health education must be stepped up through every informational vehicle, public and private. The educational resources of the dental associations are available to any and all who will use them. Health is an individual responsibility that no one can force on or provide for another; neither can health be purchased as a commodity.

The dental profession of California stands ready to provide its services and knowledge of prevention to augment the health resources of the nation, as long as the programs planned are designed to improve the dental health of our population and at the same time conserve our dental and economic resources.

Chairman SHEPARD. In case anyone doubts that Dr. Kulstad practices what he preaches, he has four children. The oldest is 14, and all of them are caries free.

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

Statement¹ of

DR. JOHN B. LOOBY

President of the

Philadelphia County Dental Society

Philadelphia, Pa.

... I wish to bring to the attention of the Commission three points which in our minds seemed to be of the first importance in the solution of the problem of oral disease.

1. Fluoridation of the water supply in Philadelphia.

2. The establishment of multiple-chair dental clinics in the health centers of Philadelphia.

3. The support and expansion of the present dental health educational programs which are now being carried out by dentists in the public and parochial school systems.

As to No. 1, the fluoridation of communal water supplies has been carefully studied by the research resources of the dental profession of the United States. It has been proven to be a safe, effective, and easily carried out procedure, there is ample scientific data to prove the efficiency of this procedure. There is probably no public-health measure which has been instituted which has had more careful scientific study than the fluoridation of water supply.

I might cite the fact that as of today more than seven million people are drinking fluoridated water, and it has already been approved for an additional 17 million persons. These figures have recently been published in preliminary Nationwide surveys, the largest conducted by the Committee on Dental Health of the American Dental Association. The largest installation is in our capitol in Washington, D. C. which supplies one million persons. The fact that good effects of fluoridated water will not be felt for a period of almost ten years after its installation leads me to point No. 2.

Multiple Dental Chairs

Point No. 2: Multiple dental chair centers in the city of Philadelphia are urgently required if the problem of child dental health is to be solved for a great number of our children.

The procedure of applying sodium-fluoride to the surfaces of the teeth of young children topically is an alternative to the fluoridation of the

water supply and might aid materially in reducing the incidence of tooth decay while we are awaiting the long range benefits of the fluoridation of drinking water.

The problem of the number of chairs to place in an efficiently conducted dental installation would be one which could be best determined by a dentist whose full time was devoted to the problem of dental health. Such a man should be appointed on a full-time basis and should devote his time to the integrating of the available facilities for dental care.

Dental Health Educational Program

No. 3: The educational programs in the public and parochial school systems of Philadelphia have been in effect over 6 years.

The impetus for this dental health educational program is the school-health act, passed by the Legislature of Pennsylvania, which requires that every child in the Commonwealth have his teeth examined by a licensed dentist every 2 years while in school. This biennial examination, where children meet a dentist under ideal conditions and discuss their dental problems individually with him, has brought remarkable results in the reduction of the number of permanent teeth lost by school children as the result of neglect.

We feel that this excellent program should be promoted in every possible way so that children will see their dentist early and regularly in order to maintain dental health. This program has shown a reduction in the number of permanent teeth lost; however, the incidence of dental decay has not shown such a marked reduction.

Fluoridation Installation Recommended

It is therefore my opinion that the dental health needs of our Nation can best be served by the immediate installation of fluoridation procedure in the communal water supply. This means, in the instance of Philadelphia—where fluorine is present in the water supply—that its concentration simply be raised to one part per million.

This percentage of fluorine has been determined and proven to be adequate. Therefore, multiple chair dental clinics should be installed in health centers in numbers which the Health Commission finds best adapted to the neighborhood, after consultation with the Council on Dental Health of the Philadelphia County Dental Society in conjunction with the Health and Welfare Council of Philadelphia.

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

In conclusion, I promise the full cooperation of the members of the Philadelphia County Dental Society with the dental health education programs as conducted in the school systems at the present time.

Statement¹ of

DR. L. C. MEIER

President

Cleveland Dental Society

Cleveland, Ohio

The major objective of the President's Commission on the Health Needs of the Nation is the making of a critical study of the total health requirements of all the people of our country.

Such a study must include a comprehensive evaluation of the present status and the future needs of the organizations and facilities necessary to provide adequate health care for all our population.

This involves many and various professional and lay groups concerned in the over-all picture of the national health problem.

The field of dentistry is one of the important professional groups in this picture. The dental profession in this country has long urged and advocated the constructive approach to this national dental health problem. This problem naturally divides itself into three different parts, national, State and local.

The American Dental Association recognizes that spokesmen of organized dentistry on a national level in conjunction with its constituent associations on a State level and its component societies on a local level have vitally and actively engaged in various programs designed to adequately meet the needs of the people. This report will deal mostly with the problem on a local level in the Cleveland area within the jurisdiction of the Cleveland Dental Society. . . .

Problem on Local Level

First, the adequacy of the number of dentists in the State or local region.

Second, the adequacy of the local public health units.

Third, the present adequacy of dental research.

Fourth, adequacy of dental clinics and dental facilities in hospitals.

Fifth, extent to which people are able to afford adequate dental care and

Sixth, the adequacy of present dental health insurance plans relating to dental care.

Before discussing these points, it should be noted that the term "adequacy" as it is used in the President's directive without specific interpretation must be regarded as vague and of necessity construed only as the opinion of the individual or group concerned.

The adequacy of the number of dentists. . . . There are approximately 1,200 dentists in the Cleveland area and about some 6,000 in the State, which we believe to be adequate and well distributed under normal peacetime conditions.

* * * * *

The present full employment at high wages should mean the lowest level of indigent group in the Cleveland area. A large majority of the people today are cared for by the private dentist and people seem to be able to afford that service.

The adequacy of the present dental health insurance plans relating to dental care.

The Blue Cross and Blue Shield plans include dental extraction costs when requested.

Goals of Action Program

In summarizing, the dental profession has endeavored to accomplish within its program of action, the reduction of dental diseases through three avenues of approach.

First, education of the child and adult by mouth hygiene programs in the schools; talks to Parent-Teachers Associations and other lay groups; and radio and television programs about the Children's Dental Health Program of the Cleveland Dental Society.

Second, through remedial services such as regular examinations in all the elementary schools, referral to private dental offices, extraction and filling services for people in the low-income brackets and topical fluoride treatments.

Third, research and utilization of its discoveries and advancements.

Fluoridation of the communal water supply, of course, is the latest advancement in research and legislation has been passed by the City of Cleveland authorizing fluoridation of the public water supply.

Actual fluoridation has been delayed due to an injunction suit but we hope that will soon be settled favorably and that fluoridation will begin.

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

The dental profession has always been active and in the vanguard in striving to solve the dental problems of this community and we believe our efforts and results obtained have been adequate and commensurate with the means at our disposal.

Total Supply of Dentists

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Commissioner **RUSSEL V. LEE**. What do you have to say about the total supply of dentists in the country at large?

Dr. **MEIER**. I believe if I am correct, there are approximately 90,000 in the country—and there are shortages, of course, in certain areas.

How that could be remedied, I do not know, but I believe there are sufficient dentists and sufficient dental students coming in to care adequately for the needs of the country, unless we embark on some larger type of program.

Statement¹ of

DR. PAUL F. O'BRIEN

Chairman

St. Louis Council on Dental Health
St. Louis, Mo.

Dental care needs may be evaluated from two viewpoints: (1) the actual needs of the people for dental treatment, and (2) the method or system of distribution.

In the St. Louis region the actual need for treatment closely parallels the national pattern. The statistics thereon are factual and already of record. The need is so tremendous that its control depends more greatly upon measures designed to prevent dental disease than upon corrective treatment. Of the preventive measures, the fluoridation of public water supplies offers the greatest promise.

It is the second viewpoint, namely, the system of distribution, that is under challenge today, and which is of such great importance to the ultimate welfare of this nation that it merits deliberate study by every citizen.

Since dental care is an integral part of health care, it is evidence that a coordinated health care program (local, State, or national) must eventually include dental care... Hence, the dental profession is vitally interested in the master planning

for health care provision, and accordingly accepts its responsibility in such planning.

The status quo of medical care provision for this Nation evolved through trial and error over several centuries, which is not only proof of practicability, but also, in a sense, an expression of the will of the people. The principal fault charged against that prevailing system lies almost entirely beyond its control, namely, the financial inability of some of the people to purchase health care. That charge is comparable to blaming the fruit because the ladder is too short to facilitate the picking. Nevertheless, it is the responsibility of the health professions to help make their services more available to all segments of the population.

In structure, the prevailing system in St. Louis, as elsewhere, is comprised of: (1) private practice, (2) insurance, industrial and cooperative plans, and (3) the public health services. The population of the Nation is comprised of: (1) those of the upper and middle income brackets who can, with some exceptions, provide financially for themselves, and (2) those of the lower income bracket who cannot provide for themselves.

Problem of Low-Income Groups

It is generally admitted that private practice, together with the insurance, industrial and cooperative plans, can be made to fall within the financial reach of the overwhelming majority of the people. The real problem, then, involves only the minority or low-income groups.

In the St. Louis region the public health departments, municipal and county clinics and hospitals, and the Health and Hospital Division of the Social Planning Council contain limited facilities to provide health care for those of low incomes. Private hospitals, and private medical and allied personnel, are satisfactorily serving those of higher incomes. It perhaps can be said that no person with the financial means in the St. Louis area is unable to obtain needed care. This is not to imply that possession of money is the only criterion, for an ill person can obtain hospitalization and limited medical care without cost at the municipal and county clinics and hospitals.

It seems highly possible that the St. Louis region could sufficiently develop and coordinate its facilities to meet a stimulated demand for care, and without resorting to a revolutionary system of compulsory national health insurance. It seems reasonable that this prosperous industrial

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

and farming community should be able to do so, if educated to recognize the necessity. For example, during the past few years about \$20 million has been subscribed for private hospital construction, and mainly because leadership proved the necessity.

Expansion of Local Public Health Services

It is respectfully proposed that a part of the resources planned to use upon a national health insurance system be allocated, rather, to aid only the minority in need of public help. That is to say, toward the expansion of local public health services, which are already well established but handicapped through lack of funds. This would serve a two-fold purpose: (1) make complete care available to the low income families, which is the immediate problem, and (2) in so doing set up a local proving ground for governmental experimentation in the field of medical care distribution—without disturbing the lives of the greater part of the population and without threat to the over-all economy of the country.

Once the public health services were developed to deliver complete and satisfactory care to low-income families, the facilities could gradually be enlarged to include those of marginal incomes who could pay part or all of their way. Thus, competition between the public health services and private practice would put both systems to the test and afford the public an opportunity for a comparative evaluation of the two. The respective facilities would be almost self-regulating, in that an increased demand for service on the one would, in inverse proportion, reduce the demand on the other.

In conclusion, the health care problem of the St. Louis region is not a critical one. Very few people suffer from neglect, unless by their own choice; and the state of health of the people in general is high.

Statement¹ of

DR. W. A. JORDAN

Chairman

Dental Health Education Committee

Minnesota State Dental Association

St. Paul, Minn.

The rate of dental disease in Minnesota is com-

¹ Delivered at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

parable to that of other States in the Union. Approximately 98 percent of the people from grade school throughout adult age show evidence of dental diseases. In fact, Dr. Peter J. Brekuhs' study at the University of Minnesota reveals a steady increase in the disease in the last 20 to 30 years.

In a survey in 1929, 3,388 university freshmen revealed an average of 9.95 teeth showing dental disease, while in 1939, 4,348 freshmen students showed 11.8 teeth experiencing dental disease, and in 1949, 4,412 freshmen average 13.7 teeth affected by caries.

One revealing fact was produced in this study: The average of filled teeth per student has greatly increased in the last 10 years. In 1929, the average filled teeth per freshman was 7.8, as compared to 8.8 in 1939, and 11.4 in 1949. These figures reveal a 45-percent increase in the number of fillings in the teeth of the 1949 freshmen of Minnesota University, as compared to the freshman group of 1929. These figures also demonstrate that more dentistry is being done with the same ratio of dentists to population.

The percentage of children showing evidence of dental disease is similar throughout the State of Minnesota. The age group 12 years shows that about 6 teeth experience dental caries, and at 17 years it is 11 to 12 teeth.

Minnesota has some 2,271 dentists available to serve a population of 2,982,483, giving a dental-population ratio of approximately one dentist to 1,300 people. The national ratio is one dentist to about 1,800 people.

Minnesota ranks third in the Nation in this relationship; New York State ranking first, with Washington, D. C., second.

Concentration in Major Cities

Approximately two-thirds of the dental population is located in the metropolitan area of Minneapolis, St. Paul and Duluth, serving one-third of the state's population. The other one-third of the dental population is fairly well dispersed geographically throughout the State to serve the remaining two-thirds of the State's population.

Every county in Minnesota has the services of at least one or more dentists. Of the 2,271 dentists registered in Minnesota, 1,905 belong to the Minnesota State Dental Association. This is a little better than 84 percent.

With its present dental-population ratio, the people of Minnesota are potentially receiving bet-

ter services than those of the average state. The ratio of dentists to population in Minnesota has been stable for at least the last 20 years. In 1930 the ratio was one dentist to 1,303—today the ratio is one dentist to 1,313 people. If the present status can be maintained, Minnesota will have sufficient dentists to give ample services to those who desire dental services.

Askov Dental Demonstration

The Askov dental demonstration is a 10-year research study to determine the value, cost and benefits of a total health community program, including dental health education, preventive and control measures and dental care to all who desire it. All preventive measures, such as topical fluoride treatment, diet control, and proper and timely brushing of the teeth, are included. Because there is no community water supply, the fluoridation of water is not included.

The program is sponsored by the Minnesota State Dental Association, Askov Community, Minnesota Department of Health, and the United States Children's Bureau. Six Pine County private dentists serve this community in the school dental office at Askov. Askov has no resident dentist. The families have free choice of participating dentists, and make their own arrangements for financing dental care with their dentist.

This small Danish community is showing how the American Dental Association's policy—that all children be eligible for dental care, regardless of income or geographic location—can be put into practice. A revolving fund has been established by personal contributions from people of the community to be loaned to needy families to pay for needed dental care for their children. No interest is charged, and the family pays back the loan to the fund in convenient small monthly payments.

It is interesting to know that of the \$363 fund established, only two loans in 3 years were requested to the extent of \$155.50, and that \$36.50 has been returned to that fund by the families making the loan. The study is beginning its fifth year this fall, and to date has shown a most favorable trend.

Dentists Adequate

It is quite obvious from the research studies conducted in the School of Dentistry on problems re-

lating to the deterioration of human teeth that the dental population of this State is quite adequate to care for the demands made upon it for dental care. This is true, in spite of the fact that such research has shown there has been approximately a 15 percent increase in dental decay between 1930 and 1950.

The adequacy of present health insurance plans relating to dental health care: At present Minnesota has no definite plan relating to insurance for dental health care. Consideration and studies are being given to the prepayment plan by the American Dental Association, and this is being watched closely by the Minnesota dentists.

Value of Good Dental Care

If the public is sincere in its desire for good dental health, the dental profession today has means which, if followed by the individual or groups, will help them to better dental health.

Dental health of the people of Minnesota can be improved, but the first step is educating the individual as to the value of good dental care. The people must want these services and then know where to find them.

At present, present dental facilities can fulfill the dental wants of its public. Continuous effort is made by the dental profession, School of Dentistry, and the Department of Health to keep the public informed as to the value and benefits of the various approved preventive measures, value of new corrective treatments and findings of research studies.

Number of Hygienists

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Commissioner DEAN A. CLARK. Could I ask a question Dr. Jordan? We had a panel in Washington on dental health, with a number of representatives present from the American Dental Association and other groups about the increased use of dental hygienists and other dental assistants, but there was no great precision in the recommendations as to how many hygienists per dentist, or dental assistants per dentist, or ratio to dental hygienists would be desirable or feasible.

I wonder if you have in mind any ideas to recommend along that line because, as you well know, you are very, very fortunate in comparison to many parts of the country in the number of dental hygienists you have in the State.

Dr. JORDAN. We are handicapped to the extent

that our law does not permit the use of dental hygienists to do certain types of preventive treatments, but they can certainly do a good service in the private office. Our study in Richmond, In-

diana, has definitely shown that where a dentist has two assistants, a dental hygienist and maybe another assistant, he can greatly increase his production.

NURSES: SERVICES AND NEEDS

Statement¹ of
MISS M. NAOMI HOUSER, R. N.
President
Pennsylvania State Nurses Association
Harrisburg, Pa.

At present, Pennsylvania ranks 45th out of the 48 States in the percentage of its total registered nurses who are actively engaged in nursing.

To eliminate waste of nurse strength, it is essential to utilize all nurses in the most efficient manner. Studies are now being conducted all over the United States on nursing functions. The Pennsylvania State Nurses' Association is starting a pilot study on the same subject. The total cost of carrying on such research is more than the membership organizations can carry. The support from foundations and governmental agencies is essential if nurses are to collect enough knowledge for constructive use on current nursing problems.

The planned expansion of hospital facilities will produce 4,570 more hospital beds. This further emphasizes the necessity for finding more nurses. This expands the need by 1,610, making total nurse vacancies 10,610.

All estimates of nursing needs are exclusive of those of the military. No one knows whether these will expand suddenly and rapidly, but everyone knows that the three armed forces have been unable to meet their nursing quotas. . . .

Legislation on Nursing Needs

State legislation to provide the public with nursing service in the kind and amount needed. (See table II).

* * * *

At present Pennsylvania has 112 schools of nursing, 108 of which offer diploma programs and four offer degree programs. Nineteen of the schools are fully accredited nationally and 69 others have temporary accreditation. The ma-

jority of these 69 schools will acquire full accreditation without difficulty. The remainder will need assistance to qualify for full accreditation.

Some of the problems facing those on the temporary basis are the small size of the hospitals in which the schools are located. This necessitates affiliations at other institutions. Generally speaking, these small hospitals are in isolated or very rural areas and have a hard time attracting the qualified teaching personnel needed for national accreditation. Also, being small institutions, their recruitment programs are frequently ineffective. . . .

* * * *

Licensing of Nursing Homes

The main reasons for past failure to obtain compulsory licensure for practical nurses have been the general feeling that the professional nurse was trying to control the practical nurse, fear of competition on the part of the professional nurse from the practical nurse group, and fear by the hospitals that the licensure of the nonprofessional group would increase costs.

* * * *

It is obvious that the number of qualified practical nurses graduated and licensed annually in the State is completely inadequate. Only with compulsory licensure will this group increase in size to the point where it can begin to fulfill the needs for this type of nursing.

Financial Aid to Students

Financial aid for nursing students, both graduate and undergraduate.

In a recent survey made by the Pennsylvania State Nurses' Association, it was estimated that one-quarter of the 112 accredited schools in Pennsylvania anticipate a 9½-percent shortage of student nurse quotas. This means that with a quota of 5,200 students the shortage will amount to about 490. This is slightly above the shortages of the previous five years.

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¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

Cost is a known factor accounting for shortage. Tuition alone is estimated slightly over \$100 a year. Administrators attribute only eight percent of the total vacancies to cost. Although impossible to prove, we suspect that some of the 2,000 student vacancies during this period were due to cost.

Another grave problem found in the survey is the large number of vacancies for prepared teaching personnel. Vacancies were estimated at 170. The anticipated hospital expansion will only increase this shortage. Advanced preparation is expensive to the nurse, for full time college attendance means cessation of income. If she attends college on a part-time basis, working and going to school, the time element presents a serious problem, for she is needed now.

Therefore, to prepare potential student nurses and potential nurse educators, Federal and State aid in the form of scholarships, grants or loans is needed to assure the citizens of Pennsylvania of adequate nursing care in illness and the prevention of disease.

Pennsylvania Unable to Hold Nurses

Improved employment conditions for all nurses: (See table IV).

The general picture of the nursing resources of the Commonwealth is that this State now produces almost one-tenth of the nurses in the country, but is unable to hold them. In 1949 we lost 2,411 nurses while New York gained 2,333.

* * * * *

Conclusion

1. There seems to be no numerical shortage of nurses in Pennsylvania, but poor utilization of present nursing resources. Better provision for auxiliary nursing care is needed to conserve professional nurses for their work. Nursing must be made more attractive if we are to consider nursing replacements by students. Retired nurses could be reactivated.

2. More approved schools for practical nurses should be established and compulsory licensure for practical nurses should be supported.

3. Federal and State aid for nursing education is needed now to fill the vacancies for student nurses and nurse educators.

4. Employment conditions for nurses need re-evaluation, with emphasis on reaching the average national salary.

Therefore, to meet the nursing needs of the Commonwealth, the nursing profession must have the cooperation of National and State legislative bodies, the citizens for whom nursing care is provided and allied groups who influence the employment conditions of nurses. Alone we cannot do the job.

TABLE I

1. The nursing strength of Pennsylvania in relation to the nursing needs of the Commonwealth.

a. Total number of nurses currently employed in all fields of nursing in Pennsylvania (estimated):

(1) Institutional.....	12,913 (b)
(2) Public Health.....	1,668 (b)
(3) Private duty.....	7,061 (b)
(4) Industrial.....	1,142 (c)
(5) School (approximate).....	1,100 (d)
(6) Office.....	1,691 (b)
(7) Miscellaneous.....	107 (b)

24,682

b. Estimated needs at present in addition to currently employed nurses:

(1) Institutional.....	1,628 (a)
(2) Private duty, no estimate	
(3) Public Health.....	2,408 (f)
(4) Industrial.....	4,884 (g)
(5) School.....	77 (d)
(6) Office and miscellaneous, no estimate	

8,977

c. Expansion in hospitals due to building programs:

(1) Hospital beds now under construction in Pennsylvania, both under the auspices of the Hill-Burton Act and private Construction plans: 4,570 (h).

d. Estimated additional number of nurses needed to staff the additions, based on 35 nurses to each 100 beds: 1,610.

TABLE II

2. The need for effective State legislation to provide the public with qualified nursing care of the kind and amount needed.

a. Auxiliary nursing personnel employed in 1951: (a)

(1) Practical nurses.....	1,247
(2) Attendants.....	6,593
(3) Nurse Aids.....	3,677
(4) Orderlies.....	2,183
(5) Ward maids.....	1,664

15,364

b. Schools for practical nurses approved by the Nurse Board of Pennsylvania: (n)

- (1) Bok and Mastbaum Vocational High Schools, Philadelphia.
- (2) Graduate Hospital, University of Pennsylvania, Philadelphia.
- (3) Irwin Avenue Vocational High School, Pittsburgh.
- (4) State Tuberculosis Hospital, Cresson.

TABLE III

3. Financial aid for nursing students, both undergraduate and graduate.

a. Addition to nursing resources through new graduates in Pennsylvania:

(1) Student nurses graduated in 1949-----	2,838 (i)
(2) Students graduated in 1950-----	3,016 (j)

b. Estimated enrollment figures for 1952-53: (e)

(1) Total student nurse quota for 1942-53-----	5,176
(2) Number of schools expecting to fill their quotas-----	75

(3) Expected number of student enrollments 1952-53-----	4,686
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(4) Expected number of students short of quotas 1952-53-----	690
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c. Relation of cost to nursing education (e)

(1) Average cost of tuition alone to student of 3-year course-----	\$327
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(2) Estimated number of students who did not enter nursing in past 5 years because of cost-----	37
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d. Teaching personnel: (e)

(1) Total number of vacancies for teaching personnel-----	170
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e. Relation of expansion programs to nursing education: (e)

(1) Number of additional hospital beds planned in expansion programs-----	3,835
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(2) Number of additional students that could be accommodated-----	469
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(3) Number of additional prepared teaching personnel that would be needed-----	32
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TABLE IV

4. Improved employment conditions for all nurses.

a. Total gain, or loss of nurses in Pennsylvania and surrounding states of similar economy in 1949 (k) in 1950 (j)

	1949	1950
(1) Pennsylvania-----	-2,411	-1,184
(2) New Jersey-----	-792	-45
(3) New York-----	-2,333	-1,027
(4) Ohio-----	-314	-124

b. Average starting salary for general duty nurses in the United States, Pennsylvania and surrounding states of similar economy in 1951: (1)

(1) United States-----	\$224
(2) Pennsylvania-----	210
(3) New Jersey-----	223
(4) New York-----	222
(5) Ohio-----	229

c. Average Weekly hours worked by general duty nurses, 1951, in Pennsylvania and in region in which Pennsylvania is located: (m)

(1) Middle Atlantic States-----	43
(2) Pennsylvania-----	44

d. Percent of total nurse population in active nursing in 1951, in the United States, Pennsylvania and surrounding States of similar economy: (b)

	Percent
(1) United States-----	60
(2) Pennsylvania-----	52
(3) New Jersey-----	56
(4) New York-----	65
(5) Ohio-----	68

Statement¹ of

MISS MARGARET RANK, R. N.

Illinois State Nurses Association, Inc.

Chicago, Ill.

Speaking as an individual citizen and as a nurse who has been employed in professional nursing for 25 years, I would like to comment that I sincerely believe that:

1. Due to changes in American culture, family life, and increased longevity, there appears to be an increasing need for hospital and institutional beds for aged, chronically ill, and infirm people in the United States. This need could be lessened if part-time housekeeping services and nursing care were available to infirm older people in their own homes. Voluntary agencies in many large cities have demonstrated the worth of such service to the communities they serve. There are practically none of these services available in smaller urban and rural communities. Promotion of the development of such services is needed in our country.

Agency Development of Nursing Care

2. A few official public health agencies operating jointly with voluntary agencies have programs which provide for the use of trained practical nurses on the staff to give routine bedside care, in private homes, to chronic invalids on a long-time basis. Under existing laws and regulations in many States, it is not possible for full-time local health units to employ practical nurses as a part of a health unit staff to carry on such a service to the people. Of course, any such use of the trained

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

practical nurse should only be made under supervision of medical and professional nursing staff. I believe that official agencies, using tax resources, should be allowed and encouraged to develop nursing care for the chronically ill, aged and infirm.

If that were possible, it would mean a new definition for a health department in the United States.

3. I believe, further, that local health departments should be allowed to collect fees for nursing care where the patient can pay for it. To make needed bedside care programs available and acceptable to all the people, it is necessary that those who are able to pay for care be encouraged and allowed to pay according to their ability.

Availability of Tax Subsidies

4. The last point I wish to bring up is the need to make available tax subsidies to nonprofit voluntary organizations for the construction of congregate living arrangements for old people who need long-time medical and nursing care outside their own homes. Such funds should be available on a matching basis through a State authority such as that set up by Congress under the Hill-Burton Hospital Act.

I believe that such support for nursing care facilities for sick and infirm oldsters is vital in reversing present trends of increasing mental hospital commitments of those aged 65 and over.

In this connection it is important to mention that in 1950 there were reported approximately 13 million people 65 and over in the United States of America. I see so many very old people living alone, becoming so lonely, poorly nourished, frail, dirty, and generally obnoxious to their family (if they have any) and to their community—committed to overcrowded mental institutions because there is no other place for them.

I do not in any way wish to minimize the importance of the care of chronic disease among the aged in general hospitals, but to point up the need for more community operated small homes near one's home community, operated by nonofficial nonprofit societies to care for those 80- and 90-year-olds who need medical supervision and considerable nursing care and whose health conditions are not enough to be remediable. Tax subsidies to such organizations proposing to operate nonprofit related institutions might give the same impetus to nursing home construction that hospital building has had of recent years.

Statement¹ of

SYLVIA MARRICK, R. N.

Director

Economic Security Program

California State Nurses' Association

Without wishing to engage in debate, I must nevertheless make a statement regarding the comments as to there being a shortage of nurses. . . .

First, there *is* a nurses' shortage, and it is critical. We are attempting to alleviate it but we have a great deal to do. At the present time there are approximately 23,000 professional registered nurses practicing in California. This is far less than the number needed today to provide safe and adequate care to the public.

This State has experienced a phenomenal growth in population, and, along with it, expanded hospital and health services. In addition, the need for more nursing personnel created by increased utilization of hospital facilities, early ambulation, and advances in medical science, has stepped up the normal demand for professional nurses. Future needs are anticipated to continue at a critical rate in the coming year.

This year directors of nursing throughout California, speaking with regard to nurses leaving the field and the inability to recruit where vacancies have occurred, have referred to the nursing shortage as more acute than at any other time in the post-war years. At the end of 1950 it was estimated by the American Nurses' Association that there were some 316,500 nurses employed in the United States, providing service to civilians. The estimate of professional nurses required to meet minimum civilian nursing needs was 381,886, a deficit of 65,386. Since 1950 the deficit no doubt has increased. Unfortunately, there are no comparable figures available for California.

Supplying the Demand

With respect to the current situation, it would appear that the one untapped source of nurses is the thousands of registered nurses, something like 40 percent in the United States and 43 percent in California, who are inactive. Many of these nurses would return to nursing if it were economically feasible.

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

According to the 1951 inventory of professional registered nurses, conducted by the American Nurses' Association, there are approximately 24,200 inactive nurses registered living in California.

As for future needs, more students must be attracted to the field. No doubt the present system of educating the student nurse is outmoded. Nursing educational standards comparable to those for other professional people could help to enhance the prestige of nursing as a field of training. The prospective nursing student will, in addition—and importantly so—weigh the economic rewards of various occupations, as well as the time and expense of preparation.

* * * * *

Salaries for Nurses

In most hospitals of the State the general duty nurse—the key bedside hospital nurse—earns a beginning salary of \$260 a month, or \$60 a week. Some hospitals, notably in southern California, pay as little as \$225 a month, or \$52 per week.

The available inactive nurse, the prospective student, and the currently practicing nurse all compare these salaries with what is being paid for other types of workers, and find that salaries for nurses are hardly commensurate with the preparation and responsibilities required. For example, the Occupational Wage Survey for the San Francisco-Oakland metropolitan area of January 1952, prepared by the Bureau of Labor Statistics, gives some figures which I can quote to indicate that disparity.

The average weekly earnings for women in certain selected office occupations in this area—such as, that the bookkeeper earned an average of \$64 a week in San Francisco—may be compared to the \$60 a week of the highly specialized nurse. Bookkeeping machine operators earned an average of \$61; senior clerks, \$66.50; secretaries, \$65; general stenographers, \$57; technical stenographers, \$61. I could quote numerous other examples.

In comparison with salaries for other professional workers, it is significant that teachers in California average something like \$3,990 per year . . . roughly \$400 per month. Teachers, like nurses, suffer depressed salaries, but because the public has assumed the great responsibility of providing better salaries for school teachers, their salaries have moved at a faster rate in the postwar years than those for nurses.

While hospital charges have increased sharply in the post-war years, the salaries for nurses have not been raised to the same extent. Hospital administrators generally plead inability to pay adequate salaries. Yet, other expenses continue to increase.

Nurses Not Covered by Legislation

Further, since the preponderance of hospitals are nonprofit associations and therefore exempt from the National Labor Relations Act, many hospitals have refused to grant their employees the same rights regarding collective economic action, as is accorded other groups of employed persons.

Nurses are further excluded from other State and Federal protective legislation covering other workers.

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Consumer of Nursing Care

The consumer of nursing care and the purchaser of prepaid medical and hospital insurance plans likewise should have the protection of complete coverage, including nursing service. We would urge, therefore, that a recommendation to include special nursing services be made for all prepaid health-insurance plans.

Lastly, and directly related to the problem under consideration—that is, the unmet need of alleviation of the nurses' shortage—must come equal protection under the law, in the same amount and degree as granted other workers under existing State and Federal legislation. Such protection, we believe, would enable the nurse to pursue her just and reasonable request for economic improvement, which we feel is essential to eliminating the nurses' shortage.

Influence of 1935 Birth Rate

I would like to add one point for the benefit of the audience. I am sure the Commission is aware of it. There is one point regarding the shortage of nurses which applies to the shortage of females in general. This year, particularly, it has become significant. In 1935 the birth rate reached a new low in this country, and it didn't commence to revive until about 1940. There is, therefore, a great shortage of 17-year-olds of both sexes in the country at this time, and it will continue for the next few years, recovering only about 1960.

Statement¹ of

MRS. MARIE B. NOELL, R. N.

Executive Secretary

of the North Carolina State Nurses' Association

Two major factors have contributed to the nursing problems in North Carolina. They are: (1) The unequal distribution of wealth and population; and (2) the large Negro population.

Social custom which dictates segregation of white and Negro populations has meant a duplication of educational and health facilities which is certainly uneconomical. However, neither of these factors is likely to change in the near future. Thus, we have the problem of providing good nursing care to the rural and Negro population as well as to the urban population. The problem of staffing the constantly increasing number of good small rural hospitals with nursing personnel is rapidly becoming acute.

The nursing population can be increased in four ways: (1) By improving and expanding the nursing education program; (2) by the more efficient use of personnel; (3) by intensified recruitment programs; and (4) by reactivating inactive nurses. Each of the aforementioned represents an urgent need in this State.

The first problem is to improve and expand the nursing education program. That such a need exists was shown in the report of the North Carolina Committee to Study Nursing and Nursing Education. This committee, sponsored by the North Carolina Medical Care Commission and the University of North Carolina, found that the quality of nursing education was poor and that our schools of nursing needed to admit 1,800 students each year and graduate 1,200 nurses in order to meet current and anticipated needs. At present our total nursing school enrollment is only 2,323 and only 723 nurses were licensed last year.

Nursing Losses in Education Process

Present statistics indicate that one out of every three students entering nursing school will fail to become a registered nurse. Two-thirds of the total loss will come before graduation. Nine percent will probably fail their State Board examinations. These expensive losses could no doubt be cut by better screening of entering students,

better educational programs, and good student nurse counseling.

Of North Carolina's 37 State accredited schools of nursing 34 applied for temporary national accreditation by the National Nursing Accreditation Service. Of these only 14 were given national temporary accreditation. . . .

The committee which studied the nursing resources and needs suggested that small schools might combine to better utilize personnel and facilities. One school is doing just that and is doing it very successfully.

In granting temporary accreditation the National Nursing Accrediting Service considered community needs, but found some or all of the following characteristics in the poorer schools: (1) Very few full-time faculty members; (2) large faculty turnover; (3) high work load for faculty and students; (4) heavy evening and night duty for students; (5) little or no planned clinical or ward instruction; (6) low number of service hours carried by graduate staff nurses or nonprofessional workers, or both; (7) high withdrawal rates; (8) low number of daily average patients in one or more clinical fields; (9) low scores on State board examinations.

The ranking of our student nurses on State Board Test Pool Examinations which are used by all 48 States, places North Carolina third from the bottom. Since the average score is so low the passing score must also be very low. It is significant that 104 of the 116 students who failed in one or more subjects on State boards between June 1, 1951, and June 1, 1952, came from schools which were not temporarily accredited on a national basis. Seventy-eight percent of the total failures were from nine schools.

Limited Experience of Hospital Schools

The limited experience afforded by many of our hospital schools of nursing has prevented their graduates from entering the field of public health. Since public-health nurses are so often far from hospitals and doctors they must have wide experience and varied education. Many of North Carolina's nurses are ineligible for entrance into any of the United States' 30-odd university and college public-health programs.

The rapid growth of our hospital system in North Carolina has created a serious shortage of administrative and instructional nursing personnel. The cost of such education is more than

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

most nurses can afford and the courses offered in this State are few. The courses need expanding and the nurses need scholarship funds.

Much of this statement has been spent on poor nursing education. This does not mean that we do not have some very good schools of nursing. Many are excellent. But those which are poor are also costly in time, personnel, and money. This is particularly true of our five Negro schools.

They and the official accrediting agency for schools of nursing have worked diligently to improve their standing, but the fact is that there is no place in North Carolina to train administrative and instructional staffs for Negro schools of nursing and the financial incentive is not strong enough to import good personnel. Therefore, our Negro population suffers a lack of well-trained nurses which cannot be blamed on lack of effort on their part. They desperately need help.

Increasing Hospital Personnel

The more efficient use of nurses is an obvious way to stretch such personnel. Recent studies referred to in the filed statement indicate that head nurses spend as much as 75 percent of their time in clerical duties, and those same studies have reported that 125 different jobs being done by nurses could be done by maids or orderlies. Such facts, besides indicating wasted personnel, must point to a contributing factor in the large number of nurses leaving the nursing profession.

The third way to increase personnel is through an intensified recruitment program. Two factors are necessary. . . One is to sell the idea of nursing as a career, through publicity directed at high-school students and their parents. The second is to make nursing as attractive from an economical standpoint as other possible careers would be. It is a rather ridiculous situation when prospective students must be told that they will study for 3 years to prepare for a career dealing with human lives for which they will receive the same or less compensation than their fellow student who will attend a 6 months' to 1 year business school.

Problem of Attracting Inactive Nurses

The reactivation of inactive nurses is a fourth source of supply for nursing. Studies are now being done to determine how many of these could return to part- or full-time nursing. Once again the economic incentive is lacking.

The average hospital in North Carolina paid \$175 per month last year to those nurses living at home. If a nurse has small children she would have to pay \$100 per month to someone for staying with those children while she works. She would have to pay income taxes on her own salary and social security tax for her employee, although that nurse probably would not be covered by social security in North Carolina. All of this would leave less than \$50 per month clear income for a 44- to 48-hour workweek. Most women do not feel the time spent away from their families is worth so little except in times of severe financial difficulty or dire disaster.

These are our problems as we see them. Their solution will take cooperative study and planning for nurses, hospitals, doctors, legislators, educators, and every individual who is concerned with his own and his neighbor's health.

Statement¹ of

MISS GLADYS WENTLAND, R. N.

Executive Secretary

North Dakota Nurses Association

Bismarck, N. Dak.

We have a population in North Dakota, of roughly 615,000 people. We have 1,924 nurses actively engaged in professional nursing—that is exclusive of licensed practical nurses. . . .

Now, we have these 1,924 nurses to cover 85 institutions that are either in the process of being built or have been built.

Their capacity, when all the institutions are finished, will be 4,781 beds. The Hill-Burton Act has done a great deal toward helping us build the smaller institutions in our particular State. These institutions are beginning to assimilate the personnel, but unless we can get our inactive nurses back into our State and get them back to work, I don't know where we are going to get the personnel to fill these places.

Loss of Nurses to Other States

Just as soon as our nurses are finished with their training courses in the State of North Dakota, and they put in 1 year of experience, the other

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

States are perfectly willing to take them away from us. As a matter of fact, they write and ask us, "Haven't you any North Dakota graduates you can send to us, we have a need for them."

But I don't see any other States sending personnel back to us. That is a point we are very sensitive about. When we stop to consider that we lost 253 nurses last year and only got 78 back, our percentage in training personnel for other States is far too great.

We do feel that most of our general duty people are being put to use, but just before I left, and at the time I was preparing this statement, I received two calls from two large hospitals: "Do you have any general duty or private duty nurses?"

If that is true in our capital city, it is also true in the larger cities in our State. And we don't know where we are going to get the nurses. We cannot manufacture them.

Some of you probably are thinking, "Well, what about your nurses' salaries in the State of North Dakota?"

Would you be interested to know that the salaries in the State of North Dakota for general duty nurses are better than those being paid in the Eastern States?

* * * * *

Hospitals Moderately Covered

Perhaps we are a little bit lax in regard to hours. That may be a point. But how are we going to stretch the nursing personnel we do have at the present time. Many of our nurses are working more than 48 hours, which the State law demands, but they need to do it to cover the institutions. You cannot let nursing service lapse by the wayside and, as I said, at the time that I prepared this brief, our hospitals and institutions were moderately covered with enough personnel to take care of the situation.

We are at a disadvantage in our State in that we do not have advance training institutions to give our people further training, particularly in psychiatry and tuberculosis; but at the present time we have our plans all made, and are ready to ask the next legislature for funds, so we can at least have facilities for our student nurses in psychiatry and tuberculosis.

We have not waited for Federal aid, or anything of that kind. We have attempted to go ahead and solve the problem in our own fashion.

Statement¹ of

MISS HELEN E. KINNEY, R. N.

President

Missouri State Nurses Association

Jefferson City, Mo.

According to the latest available data from the office of the State Board of Nurse Examiners, Missouri has at this time 11,373 currently active, registered nurses. Approximately 14 percent of these nurses, however, carry multiple or dual registration, which means that at least a portion of the 14 percent are residing and working in other States, even though they continue to keep their registration in the active status in Missouri.

During the past few years, a greater percentage of nurses have left Missouri to work in other States than have entered practice in the State by reciprocity. . . . As of this date, since January 1, 1952, 208 nurses from other States have applied for licensure in Missouri, but 424 Missouri nurses have become licensed in other States.

Nurses Married to Servicemen

Records show that nurses married to men in the armed forces leave this State in order to be near the camps where their husbands are stationed, but many of the younger nurses are leaving the State because better economic conditions and personnel policies for nurses are offered in other States. Some married nurses enter other fields of employment or retire from nursing because administrators are not cognizant of their needs for better personnel policies which will enable them to meet their obligations as wives and mothers.

Nurse Shortage in Hospitals

It is a well-established fact in Missouri, as in most of the other States, that there is a great need for additional nurses, and in many rural areas this need is critical. . . .

It has been noted that some hospitals are having to close entire floors due to lack of available nursing personnel. In spite of this, several new hospitals have been constructed in Missouri under the Hill-Burton Act and two new veterans hospitals are ready to open their doors.

In constructing these hospitals, evidently few plans have been made for obtaining nursing personnel. The State organizations of professional

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

nurses would like to recommend that qualified nurses be asked to be present in an advisory capacity when plans are being developed for the construction of new hospitals or for the construction of additional bed space in the older hospitals.

* * * * *

The Missouri nurses are unable to meet the nursing needs in Missouri and are also unable to meet the quotas set up by the armed forces. Any qualified nurses taken for the armed forces will increase the critical nursing shortage. We would like to commend the Army and the Navy on their present use of nursing personnel and would like to suggest that continued study of nursing functions would be advantageous.

Hospitals Opening Doors to Negro Nurses

The Missouri State Nurses' Association does not condone discriminatory policies which may exist with respect to nurses in minority groups. In the past few years, more hospitals have opened their doors to the Negro nurses with most gratifying results.

**Statement¹ of
MRS. EMMA ANTCLIFF, R. N.
Michigan State Nurses Association
Lansing, Mich.**

Basic Causes for Shortage

Some of the basic causes for the present nursing shortage are:

1. *Increased demand.* Though there are more nurses working in this State than ever before, the demand for their service grows faster than their numbers. The demand is both for more nurses and for nurses with greater and more diversified skills.

Hospitals alone account for a large share of the shortage: hospital beds in this State have increased in number from 54,465 in 1940 to 64,952 in 1950. The population grew in the same period from 5,256,000 to 6,418,000. And of every 100 new babies added to the population last year, 95 were born in hospitals.

The demand for nursing service has become vocal and also financially audible. Since more than half of the people of Michigan are covered by some form of hospital insurance, they are able

to have hospital care when needed, and with it they expect a high level of nursing care.

2. *Competition of other fields.* At the same time, the young women and young men who might become nurses have thousands of other employment opportunities in a heavily industrialized state. Actually only 1 out of 25 girls graduating from high school in Detroit entered nursing, as compared with 1 in 18 for all of Michigan and 1 in 14 for the Nation. Yet one out of every 10 or 11 must enter nursing, if quotas are to be filled.

3. *Low birth rate.* There are fewer young women to draw from at this time because 17 and 18 years ago—during the depression years—the birth rate fell below normal. Colleges and employers, as well as schools of nursing, are confronted by the consequent loss in teen-agers today. The number of high school seniors in Michigan dropped sharply after the onset of World War II, and is still 12 percent below what it was in 1940-41. Estimates for the future do not promise to reach pre-war levels before 1955.

4. *Good economic conditions and marriage.* Favorable economic conditions have made it possible for many young women to marry immediately on finishing high school; thus, fewer enter the employment field. Approximately 50 percent of the nurses graduating from professional schools of nursing are married within the first year following graduation. Many of this group leave nursing immediately or soon after.

5. *Other factors involved.* Among other factors involved are:

(a) *Increased longevity.* Michigan's population of 65 years and over has increased in 10 years from 331,000 to 453,000. A consequent increase in chronic and degenerative diseases places an additional responsibility on health agencies and professions.

(b) *Changes in hospitalization.* The average daily census of patients in all Michigan hospitals has increased by about 25 percent in the last 10 years. At the same time, the shorter average stay in a hospital calls for more skilled nursing care during the first critical days.

* * * * *

(1) *Nurses needed in Michigan.*—The number estimated as needed in Michigan by 1950 (according to a study made in 1945) was 16,000 to 18,000 professional nurses in active or semiactive status. There are now, however, only 13,193 who are registered in this State and active in nursing; 7,853

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

others are registered but inactive, largely for personal or family reasons. A shortage of at least 4,000 professional nurses in the State's total need is reflected in practically all fields of nursing.

(2) *Hospital nurses needed.*—Of Michigan's active registered professional nurses 9,075—the largest number—are employed in hospitals. Fully 3,000 more could be absorbed in the various types of hospitals now existing or being enlarged, without taking into account the new hospitals under construction. This figure assumes that professional nurses will have the cooperation of practical nurses, auxiliaries, and nurses' aids (referred to later) in order to make the most economical use of their skills.

(3) *Public health nurses needed.*—Michigan needs approximately 400 additional public health nurses if it is to meet even the minimum recommended standards of 1 per 5,000 population. We have 869 now. Not only more, but better prepared public health nurses, are needed; only half of those now employed in public health positions meet minimum requirements.

(4) *Nurse educators needed.*—Key persons in the education of our present students, and of any increased number of students, are well qualified faculty members. The need for them may not be obvious to the patient today, but it is crucial if he is to have good care tomorrow. Our schools reported this fall that they could employ 40 more nurse instructors and 72 more clinical supervisors, even without admitting more students.

(5) *Practical nurses and auxiliary workers needed.*—There are over 3,000 practical nurses who have met membership requirements in the Michigan Practical Nurses Association. Michigan needs many more trained practical nurses, attendants, and nurses' aides. They are essential to the provision of adequate nursing care in hospitals, nursing homes, and private homes.

(6) *Student nurses needed.*—Michigan needs 2,000 student nurses annually to fill its professional schools. An estimated 1,500, an increase over last year, have been admitted in 1952. As compared with 1940, the number of new students in recent years shows a substantial gain. The record of 5 years during World War II, however, has not yet been equalled. During three of those years (1943-46) new students numbered more than 2,000.

(7) *Scholarships needed.*—The cost of nursing education averages \$200-\$400 for educational ex-

penses alone. Added to this cost is the student's need for spending money. A serious obstacle which undoubtedly is preventing some young women from applying is the need to contribute their earnings to their families.

Professional nurse students who need a scholarship or loan can usually obtain it locally or through a State organization. However, directors of schools estimate that about 200 potential students found finances too great a barrier this year and did not enter. Reluctance to borrow money and financial need in the family prevented them from applying.

Practical nurse students often need a scholarship or loan. Some funds are available but more should be established by friends of the various schools and members of the practical nurses associations.

* * * * *

Good economic conditions for nurses in Michigan are spotty and fall into a definite geographic pattern. The Michigan State Nurses Association has surveyed this situation yearly; and through its sections, has made recommendations regarding minimum salaries and working conditions. There has been good cooperation with allied health agencies in implementing these recommendations. In Detroit and Flint, salaries are as high as anywhere in the country, and hours of work and other benefits are excellent. A comparison of average general duty starting salaries reveals:

	<i>Per month</i>
National	\$224
Michigan upstate	225
Detroit	250

In Michigan, hospital nurses do not tend to locate in areas where personnel policies are above average. Rather, they tend to accept employment near their home.

Statement ¹ of

MRS. MYRTLE H. COE, R. N.

President

Minnesota Nurses Association

St. Paul, Minn.

I might say . . . that in all the shortages of nursing personnel, the narrowest bottleneck is that of teachers of nursing. I think that fact is very important, because so many people feel that to own many schools throughout this State . . .

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

is the right answer, that if we were to open a school in every local hospital, girls from that community would go to those schools and would be likely to stay in that community.

There are two errors in that thinking. First, there are not faculty members for any more schools than we have at the present time. In fact, our schools of the present day are not able to obtain the number of faculty members they need. |

Secondly, the girls who go to local schools do not stay there. I have talked with the faculties in those schools, and they consistently tell us that their students, as soon as they finish, say: "We have our wings and we can fly on." They don't stay in the local communities after all.

Federal Aid for Nursing Education

While efforts will be made to extend appropriations for scholarship aid during the biennium 1953 to 1955, the Minnesota Nurses Association is on record as approving—and not only approving but pleading for—Federal aid to nursing education, and wishes to reiterate its approval before representatives of the President's Commission on the Health Needs of the Nation.

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Unfortunately, there are certain segments of our population, and certain groups, even of the health workers, who have not made it possible for nursing education to be benefited by Federal aid. I only hope that their children are not some of those who need nursing care today in this epidemic.

Information reveals the fact that colleges which offer programs of study for graduate students are consistently showing an enrollment considerably below capacity. This is due, in a large measure, to two formidable barriers: One, the paucity of scholarship aid for graduate nurses; and two, the reluctance of health agencies to release personnel for further preparation because of the difficulty in finding replacements.

Jump in Hospital Beds

I might say here that we can see one of the reasons why we have a great need for more nurses in this State, if we realize that just since 1948 there has been a 31 percent increase in the hospital beds of Minnesota; and of course we have not been able to keep up with any figure of that sort in our supply of nurses.

I think that when we stop to think that, while in the last decade the population of Minnesota

has increased by 150,000, the population group from which we recruit students (from 10 to 19) has on the other hand fallen by 50,000, it is miraculous that we have been able to in any measure at all keep up in our recruitment of girls for schools of nursing, particularly when there are all these other health needs or health fields which are so attractive to young women.

Statement¹ of

MRS. EVELYN STONE, R. N.

Missouri Association of Licensed Nursing

Homes

St. Louis, Mo.

I am a nursing home operator, and have been for more than 20 years. Also, it happens that I am the president of the Missouri Association of Licensed Nursing Homes, so I represent nearly 90 of the 265 nursing homes in the State of Missouri.

Problems of the care of the aged, infirm, and chronically ill, have affected me personally and professionally, and as yet we have had very little opportunity to work toward the solution.

What are the problems?

Displacement of Older Worker

One that I believe stands out as the fundamental problem—a solution to which would solve many that are dependent upon it—is the one that arises out of the increasing social and economic pressures and trends that limit the productivity of the individual, say at the age of 65:

"You are no longer an efficient part of our producing machine. We need your job for someone younger who does not now have a job and, furthermore, after you have worked hard all of these years you ought to be entitled to retire and take it easy for the rest of your life."

This is the commonly accepted social and economic goal that we have been approaching over the last two or three decades, in spite of the fact that all of the efforts of science and medicine have been exerted in the direction of lengthening the life span of human beings and giving them an increasing use of their talents and abilities for a longer period.

When the number of people over 65 years of age increases 35 percent in 10 years, and laws and in-

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

dustrial pension systems constantly work to reduce the productive working years of wage earners in all fields, the scope of the problem becomes readily apparent.

Productive Capacity of Aged Ignored

More and more people are being relegated to means of support other than their own productive labor, without reference to their capacity, much less their individual desires in the matter. Whether a man who is forced to retire from his life's work will shortly thereafter begin to deteriorate mentally and physically is a matter of conjecture, but it is certain that the number of older people is increasing at an amazing rate, and a certain proportion of these people will always be in need of medical and nursing care.

We must have, and do not now have, adequate facilities to care for these people.

It is no secret that general hospitals have had their facilities taxed to the limit, and in most cases are barely adequate for community needs. To relieve this pressure, and to meet the other problem, we suggest that all encouragement should be given to the establishment of institutions whose services are limited to patients who are convalescent or chronically ill. In effect, these institutions should be qualified to meet the problems of the aged or chronically ill in every respect, but just short of surgery.

There are a few institutions of this type now in existence, but some hospitals are planning the addition of such facilities, and many more private facilities should be encouraged.

Establishment of Standards

Standards of medical and nursing care should be established in these institutions that would insure that aged, infirm, convalescents, or the chronically ill would be guaranteed the medical and nursing care required in each case.

In this connection, old age assistance and public pension plans should be revised to meet more realistically the needs of the pensioner. If he is receiving State or Federal aid and needs medical or nursing care, the aid should be geared to a scale that in each case would insure that competent physicians and nurses give the necessary treatment, and in an institution that has adequate facilities for the care of such cases.

It is suggested that such a program would encourage young women to enter the nursing profession, for a whole new field is opened for nursing

service in the area between private duty and general hospital duty. Also, institutions of this type would be geared to the advancement of learning in the field of geriatrics. There has been relatively little done in this field, but it will become increasingly important as the number of older people increases.

Recommendations

By way of summary, therefore, we recommend that the problems of care for the aged, infirm, and chronically ill be approached in this way:

First, establish institutions designed for the care of the aged, infirm, and chronically ill.

Second, maintain the highest standards of care and efficiency in these institutions.

Third, adjust public welfare aid programs to meet the actual needs of the recipient on a realistic basis.

Fourth, by these means and others, encourage people to enter the nursing profession and improve the practice of geriatrics, both of which would be attracted to the new field.

Statement¹ of

MRS. FRANCES BARCLAY, R. N.

Treasurer

Ohio Association of Nursing Homes

The nursing, rest convalescent and boarding homes herein referred to as nursing homes are an important factor in the care of the aged, infirm and chronically ill, not only in the State of Ohio but throughout the entire United States. Ohio has 479 nursing homes with 8,576 bed capacity, making an average of 18 beds per home.

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The (nursing home) operators in Ohio organized 5 years ago for the purpose of raising standards, for exchanging information, and for establishing a code of ethics. Since Ohio was the second State in the United States to organize, there were not too many sources of information available. However, Indiana, Michigan, and Ohio held a midwestern conference, asking other States to join, and the American Association of Nursing Homes was the result of this midwestern meeting.

Payment for Care of Aging

The problems of all nursing home operators seemed to be much the same. The greatest of all

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

these is the small amount of revenue derived from the care of these people.

Many patients cared for are transferred from hospitals, where the rate is from \$10 to \$20 per day. Very few nursing homes are receiving more than \$6 per day, but must maintain an adequate staff of nurses and other help to care for these same patients. The rest and boarding homes are caring for ambulatory patients, for which \$85 per month is about the maximum rate. The fact that these homes are privately owned does not mean they can purchase food for less or keep efficient help and render the services which are necessary.

If we are to become a part of the health plan of the United States, there should be something more definite worked out as to payment for this care of our aging population. The nursing homes are under social administration inspection for safety, sanitation, number of patients and personnel before licenses are granted.

Problem of Financing

The operator who has a small home is unable to expand or purchase a suitable building due to the small amount of profit which she invariably puts back into the business. This often creates hardships as banks and investment houses are loath to grant loans on this type of business. This has become a worthwhile professional business and should be so evaluated.

Some of the more fortunate operators who may have owned buildings have expanded and improved their facilities until their investments are now in five figures; it was not accomplished through any help from the Federal or community finances or agencies.

Acute Shortage of Homes

The shortage of homes is also acute. The homes are paying as much and offering every possible inducement to get and keep nurses to carry on this work. Does the responsibility of caring for these aging people rest with the county, State, or the Federal government? The philanthropic and re-

ligious homes are overcrowded; the general hospitals and the mental institutions are caring for senile patients who rightfully do not belong there.

What the average old or sick person wants and needs more than anything else is a place as near like home as it is possible to have. Who can supply this type of home for them but the nursing home operators? The sooner this is recognized and made a definite part of a program with unified regulations and a better plan for adequate payment, the more smoothly the care of our aging population will move forward.

Financing of Homes

Commissioner ELIZABETH S. MAGEE. What suggestion do you have about how these homes could be financed? I notice you said you thought that was the difficulty.

Mrs. BARCLAY. If there could be a closer arrangement between the Federal—I am speaking of either Social Security or old age grants which are received through the State—and perhaps our county welfare, if an amount could be made available—in our own county it was recently, but in a great many counties there is not enough supplementation. The families of a great many of these older people—some of these older people have no families at all—no one at all, and they are dependent entirely upon our Federal grant. It just is not sufficient.

That is why some of the nursing homes just do not have enough to have personnel and proper food.

Commissioner RUSSEL V. LEE. What is the bare figure for the cost of caring for a person in a nursing home?

Mrs. BARCLAY. Of course between rural and city homes there is a variance, but a fair estimate runs about \$4.25 a day. It is being done for much less but it certainly should be because, as the nurse spoke of, it is a matter of paying for these things. We are licensed and we must have one nurse for eight persons. That is not adequate for a 24-hour day service.

PUBLIC HEALTH: ORGANIZED COMMUNITY EFFORT

Statement ¹ of

DR. L. P. WALTER

**State Director of Local Health Services
Austin, Tex.**

The death rates from certain preventable causes in Texas, as compared with the United States as a whole, greatly indicate that there is a tremendous need for the expansion of the existing public health program in Texas.

The death rates from typhoid fever, scarlet fever, diphtheria, whooping cough, malaria, dysentery—all forms—acute anterior poliomyelitis, complication of pregnancy, infection of the newborn, prematurity, tuberculosis, are above the average for the United States. Dysentery and diphtheria mortalities far exceed the average for the Nation. Typhoid fever and dysentery rates have long been used as a barometer of public health activity. The death rates from dysentery and diphtheria alone will clearly indicate the need for the expansion of the public health program in Texas.

These death rates can and should be reduced. The question is no longer controversial—can a public health program reduce death rates? We have demonstrated that the mortality can be reduced when an adequate modern local public health program is established.

The greatest public health need in Texas is the establishment of modern local health unit service for the entire State. At this time, there are only 48 health units in Texas, serving 57 counties. Since there are 254 counties in Texas, there are large areas which are not receiving the benefits of modern public health protection.

If 32 additional health units can be established, the entire State will be covered with local health unit services. The question then arises—why haven't these health units been established? The answer is—the lack of funds and personnel. When adequate funds are secured personnel are always secured. Many of the existing rural areas cannot raise funds for financing the program. Whenever several adjacent counties cooperate in financing a local health unit program, sufficient local and State funds are not made available.

Financing Health Units

The health units at this time are financed on the following basis: At least 60 percent of the funds must come from the local appropriating agencies, and when funds are available 40 percent are furnished by the State. No one health unit receives over \$50,000 unless specialized funds are utilized for a specialized program for demonstration purposes.

At this time the public health program in Texas is financed by Federal, State, and local funds. When Federal funds are accepted, they are used on the same basis as State funds and are allocated to the local health units on that basis. When the 60 percent local appropriation is matched with the 40 percent from the State, the 40 percent may be entirely funds originally received from the Federal government.

Reducing Preventable Disease Deaths

The deaths from preventable diseases can be reduced by the establishment of additional modern local health units. The establishment of these units will require more funds. If sufficient funds are appropriated, adequately trained personnel can be secured.

The Texas State Health Department carries out a recognized "preventive" public health program. Neither the State health department nor the local health units have the responsibility of indigent medical care. Treatment is not the responsibility of the health department. The ill individual is directed to the practicing physician.

Quality of Medical Care Endangered

We are opposed to compulsory health insurance and what is commonly known as socialized medicine. Socialized medicine will reduce the quality of medical care and indirectly reduce the quality of public health work.

A wide experience over a long period of time has proved that the limited funds available to the State health department and the local health units can be spent more economically and efficiently with a program of prevention only. Preventive medicine and public health is a specialty. This specialty is recognized by the American Medical Association, and the American Board of Preventive Medicine and Public Health. If public health departments enter a treatment program,

¹ Delivered at Regional Hearing in Dallas, Texas, August 18, 1952.

funds and personnel would be diverted from the preventive aspects of a public health program; thus a recognized preventive public health program as such could not be carried out.

High Mortality

In summary, let me say that evidence has been presented which definitely shows that many important public health problems exist in Texas. There exists a high mortality from preventable causes. This high mortality rate can be reduced by a modern, adequate public health program. Thirty-two more health units should be formed immediately in Texas. These units can be organized if funds are made available for the employment of personnel. The State health department and the local health units have the responsibility of a preventive public health program only.

Statement ¹ of

DR. JAMES B. DIXON

**Commissioner of the
Department of Public Health
Philadelphia, Pa.**

I think that I shall preface my remarks by saying I am speaking from the frame of reference of a local health officer, who at the same time also has a basic administrative responsibility for the administration of medical care programs for the economically dependent group in the community. I am also speaking from the frame of reference of municipal public health, rather than rural public health, and as a health officer of the third largest municipal jurisdiction in the country.

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Here I list what I would regard as some generic means and problems of public health as we see them here.

Decentralized Programs

In the field of public health and preventive medicine there is a plan in Philadelphia to decentralize services down to community regional levels and to generalize the programs in these health regions. It is clear, however, that the effective functioning of a decentralized generalized program rests heavily upon the capacity of the Department to obtain extremely skilled public health workers, particularly from the fields of medicine, nursing, and health education.

While many of these workers can be drawn from health programs elsewhere, it seems now quite likely that, if the Department of Public Health is to achieve its program goals, it will have to occupy itself with intensive training programs for personnel of all levels. This fact becomes sharply apparent when it is realized that of the presently projected ten health districts, only one can be said to be reasonably adequately staffed at the present time. We shall, therefore, need funds and facilities for the training of personnel.

The Tuberculosis Problem

Lest we overlook the fact that the great urgency or need for medical care should crowd the problems of classic public health out of our picture, I think that it might be well to review the fact that here in this municipality there still exists a basic public health need of that basic program. For instance, the problem of tuberculosis is not adequately met. It is estimated that there are in excess of 1,000 open active cases (of tuberculosis) at large in the community at the present time.

The greatest problem in the control of tuberculosis is the distinct shortage of beds for the tuberculosis patients. Part of this need is being met through the acquisition by the State of Pennsylvania of Lankenau Hospital. This will not, however, meet the entire problem. The same problem exists even more sharply for other categories of chronic illness than for tuberculosis.

Mental Health

In the field of mental health there is a tremendous demand in the community for the creation of additional mental health services. At the present time the facilities for managing problems of the acutely mentally ill are in themselves inadequate. There is a great need to increase both the in-patient and out-patient aspect of these facilities. It is hoped that it may be possible to explore the creation of mental hygiene clinics as the proper function of the decentralized health center.

Dental Health

Dental public health in the City of Philadelphia in the official agency is completely inadequate. There is an important need to strengthen this program.

Environmental Sanitation

The environmental sanitation program of the community is weak. Philadelphia, because of the

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

provision of her new charter, has an opportunity to rapidly develop a modern program in environmental sanitation, with heavy emphasis on the control of food and food products, pollution of the air, occupational health, hygiene of housing, and home accident prevention.

Home Care

It seems to me one of the primary needs can be summed up in the consideration of home care. The city of Philadelphia has a great need to transpose many health services from the institution into the home. A study is now under way to determine the number and type of patients now hospitalized at Philadelphia General Hospital who could more effectively, both from the social and economic points of view, be cared for in their homes. Based upon the results of such a study, the Department of Public Health should provide community leadership for the development of home care programs, and probably also direct health services particularly in medical and nursing fields through its health centers as such programs get under way.

Teaching

If public health programs of the future are to meet their obligations, it becomes increasingly necessary that the practice of preventive medicine become an ever more important part of the practice of medicine as a whole. The Department of Public Health of Philadelphia has as one of its major obligations a responsibility to provide, particularly for the disciplines of medicine and nursing, undergraduate training fields which would enable educators in our community to incorporate the concepts and practices of preventive medicine more completely into the medical school curricula.

The effective development of such a training program might, indeed, have much more impact upon the health of the Philadelphia community than any quantity of direct services which the community could provide through its health department.

Financing

The problem of financial support of health services is always a critical one for any health department. This is increasingly complicated in Philadelphia because of the relationship between preventive and therapeutic services. There would seem to be need here to review the total pattern of

financing of health services to reassess the financial responsibility of the local, State, and national jurisdictions.

In addition to this, and particularly if the community places upon the Department of Public Health the responsibility for the operation of health maintenance functions in its Health Centers, we shall also have to re-examine our present concepts concerning the individual's responsibility to meet the cost of public health services.

Major Public Health Needs

In summary, then, it may be said that some major public health needs of Philadelphia are:

1. The acceleration of decentralized health services.
2. More beds for tuberculosis.
3. A program for mental health.
4. More public health dentistry.
5. Programs of home care.
6. Improved use of the official agency for undergraduate and graduate teaching in preventive medicine and public health.
7. A better program of environmental sanitation.
8. Personnel and sources of funds to meet the communities' demands for programs.

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Hidden Health Needs

Commissioner ALBERT J. HAYES. Dr. Dixon, I wonder whether you would take a few moments to clear up something I am sure the Commission would like to have cleared up. When we talk about health needs we are assuming that we know something about the health needs, and our opinions are usually based upon statistics gathered by someone—the collective experiences of doctors and so on—or upon someone's estimate.

Would you like to give the Commission your opinion as to health needs that we know nothing about at all—people who have never been near a doctor, who should have gone to doctors, should have gone to clinics, . . . people who, because of the dollar barrier, perhaps, or because of lack of knowledge, have never even been near a doctor—or members of their family who have never been near a doctor? Is that a problem?

Dr. DIXON. It probably is a problem, though I think I would not be able to give you statistics. But this one fact would tend to bear out what you

say. That in local medical care and public health administration, as fast as you transpose one load of persons—perhaps to a third-party carrier, perhaps to some other community agency—instead of finding an economy in the operation of your health services, the gap is always filled up by people who apparently did not have any health service before. Now, exactly what that deficit is, I think it would be extremely difficult to say. It has always been, in my experience, in excess of our capacity to stay ahead of the program.

Commissioner HAYES. What brought this to my attention was your statement that the individual does have some responsibility with regard to his health and the health of his family, and, assuming that we agree upon that, I am wondering if it is not your opinion, then, that there is something lacking in our educational facilities insofar as health education is concerned; because if it is true that the individual has some responsibility in that regard, then does not society have some responsibility to advance and extend health education so that the individual will recognize his responsibility?

Dr. DIXON. Yes, I would also have to concur with that, and say that community utilization of health facilities is very poor—very poor indeed, generally limiting itself only to utilization—free utilization in terms of adequate utilization—in terms of emergency illness. There is great need to reinforce, somehow, through this technique of health education—or whatever you wish to call it—in the minds of the people who require services, this business that disease is preventable, and that the initiative rests upon the individual to seek out the services which will prevent disease.

Statement¹ of

ROBERT DYAR, M. D.

(Representing Wilton L. Halverson, M. D.
Director of Public Health, State of California)
San Francisco, Calif.

I shall limit my remarks to a discussion of public health problems, touching briefly on some major problems in the public health field.

Areas without local public health departments: There are 16 counties, with a total population of approximately 219,000, representing 2.1 percent of the total State population, which are not served

by organized local health departments. Financial assistance roughly equivalent to \$1 per capita (\$0.81 State and \$0.20 Federal) has been available annually to these counties for 5 years, but partly as a result of geographic location, low population density, and low local tax revenues, it has proved difficult for these counties either to devise or provide the organization necessary to provide essential public health services.

It is difficult to demonstrate statistically the public problems in these areas. They appear to have higher maternal and infant mortality rates than the State as a whole. There is a significant delay in reporting tuberculosis, and major sanitation problems are known to exist. An effective and economical administrative mechanism, consistent with the philosophy of local government for meeting the public health problems in these areas, has not yet been found. There is need for careful study of rural areas such as these to determine how modern public health protection can be economically provided.

Local Health Department Burden

Areas with local health departments: The impact of a steadily increasing population in California throws a greater burden on all local health departments to meet the growing problems, even without increasing the present general level of services. Although 97.9 percent of the State's population is served by 53 organized local health departments, services available are, in general, inadequate to meet the total need.

If personnel standards proposed by the American Public Health Association are applied, only 1.1 percent of the total State population is served by health departments having the recommended number of medical, nursing, and sanitation personnel. It should be noted that even if budgetary provisions were made for positions to meet these standards there would not be trained personnel to fill them. There is an urgent need for the training of more professional public health workers.

Health Facilities Need Expansion

Health center facilities.—There is urgent need for adequate health center facilities in all parts of the State. To date, health center construction has not kept pace with the needs of existing departments. Of the 53 organized health departments in California, only 5 have adequate physical facilities; 9 are without any acceptable facilities, and 29 have less than 5 percent of the acceptable

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

space needed to furnish minimum services. There is at present a total of 545,000 square feet of acceptable space; there is a need for a total of 1,083,000 square feet.

California's rapid population and industrial growth during recent years has presented very real problems in expanding the capacity of hospitals and health facilities to meet the needs of residents of the State. California has approximately two-thirds of the hospital and health facility capacity necessary to serve adequately residents of the State.

Many rapidly expanding areas of the State have considerably less than two-thirds of their needs met by existing facilities. The State is bearing a major part of the impact of a very substantial population shift within the United States. The State's population increased from 7 million in 1940 to 10.5 million in 1950. The Census Bureau estimates the 1960 population will be from 13,380,000 to 14,919,000.

Federal Funds Limit Bed Expansion

Since World War II approximately 20,000 hospital beds have been built in California, only 3,000 of which could be assisted financially under the Hospital Survey and Construction Program, because of the limitation of Federal funds available to this State. Despite this record, hospital construction has barely kept pace with the needs of the added population, and the present total deficit is essentially that existing at the close of World War II. Population trends indicate a continued need for an accelerated building program, if any impression is to be made on the accumulated need. There is need for continuing the Hospital Survey and Construction Program after 1955.

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The basis of distributing funds to States should be modified to permit recognition of accelerated population growth. Only then can California communities, now straining their local resources abnormally to meet the needs of new residents for schools, churches, roads, and innumerable other public improvements, develop the hospital facilities necessary.

Radiological Health

The increasing use of radioactive materials in civil life by medical and industrial groups presents a new health problem.

Fundamentally, there are three fields of interest: (1) research and teaching, (2) preventive

public health, and (3) responsibility for disaster preparedness. Underlying these basic program interests are the factors of personal protection and the prevention of environmental contamination. Research or fundamental fact-finding is essential before practical administrative measures for personal and environment protection can be developed.

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We acknowledge that State and local agencies have responsibilities which must be met to prevent misuse of radioactivity. However, the Federal Government, if it plans to assist State and local government in meeting their coordinate and regulatory responsibilities, must plan to stimulate the fundamental research on which proper administrative patterns can be developed.

Air Pollution Problem

The seriousness of the air pollution problem in California has increased rapidly in recent years until today air pollution ranks second only to water resources and transportation as a factor limiting ultimate growth and development of our major metropolitan centers.

Although air pollution is a matter of grave economic consideration, the principal concern of the public is with air pollution as a health problem.

Today public health agencies can neither affirm nor deny the public health effects of air pollution. Research is essential, first, to identify the physiological effects of the most pertinent of the common ingredients in polluted urban air; and second, to relate human morbidity and mortality to exposure to polluted air. Without such research, official health agencies are unable to discharge their responsibility to protect and promote the public health by constructive, preventive measures.

Mental Health

There is a continuing need for Federal mental health funds which will be available to local communities to enable them to experiment with various methods of securing clinical service.

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Since this understanding of clinical service is relatively new among professional workers, we cannot realistically expect communities to set up such service out of their own funds until they have had some opportunity to experience the benefits of this approach. Limitation of funds has meant that local plans have been necessarily

limited, and many enthusiastic groups have been discouraged by the impossibility of obtaining funds.

Problem of Chronic Diseases

During recent years, the problem of chronic disease has received increasing recognition and consideration. In 1947 and 1948 the California Department of Public Health conducted a State-wide chronic disease investigation, publishing "A Chronic Disease Program for California." In 1951, the Governor's Conference on the Problems of the Aging stressed health problems. Both the California Medical Association and the California Osteopathic Association have appointed chronic disease committees.

Rehabilitation, public and private facilities and services for medical care, facilities for care of elderly disabled persons, public education and other services are all components of an adequate approach; but the most fundamental attack on any disease problem is prevention, and disease problems of the aging are no exception.

Although there is great need for further research, considerable knowledge already exists which, if fully applied, could prevent a vast amount of disease, disability and premature death. Emphasis must be placed on the great opportunity and the responsibility of the individual physician and the private hospital for the early detection of abnormalities, prompt medical care and adequate rehabilitation.

Alcoholism

Millions of dollars are spent annually in California for police and related activities, institutional care, and welfare services for alcoholics. These efforts are not designed to reduce the incidence of prevalence of alcoholism, nor to stimulate prevention and rehabilitation.

By and large, alcoholism is still dealt with primarily as a criminal problem. However, the hospitals of the California Department of Mental Hygiene now admit about 2,000 alcoholics annually, although at present they can do little more than provide custodial care, and few alcoholics come to the attention of those interested in rehabilitation and in the prevention of alcoholism.

The California Special Crime Study Commission has stressed the futility of our present practice of treating alcoholics as criminals. This viewpoint is in agreement with the findings of the Governor's Conference on Mental Health held at

Sacramento in 1949. The California Medical Association appointed a special committee to collate information for consideration and evaluation in meeting the problem of alcoholism in California.

... There is a great need for all scientific and professional groups concerned to participate in research on every aspect of the problem of alcoholism. Specifically, research is needed on the physical, mental and social factors associated with alcoholism to develop better methods of prevention, treatment and rehabilitation.

Acute Communicable Diseases

In the acute communicable disease field, there are three major problems:

(1) poliomyelitis and the other neurotropic virus diseases, with the fearful psychological and medical care implications;

(2) acute respiratory infections, with their confusing and unknown etiologic and epidemiologic patterns; and

(3) diarrheal diseases, producers of an enormous morbidity. In this last category, our problem has been particularly acute in the San Joaquin Valley, with its large migrant population, and in the mountain recreational areas, also with large transient populations.

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Conclusion

In retrospect, the public health accomplishments of the people of this State—despite a population growth unprecedented in history—result from the activities of no single agency of government and no single group in the population. Responsibility for California's health record rests, in large measure, with the people of the State, working together under the leadership of the private and public health agencies and the medical and allied professions. There is ample reason to believe this same team can cope with the current health problems.

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In some of the areas discussed earlier, such as the health problems of the aging, the chronic diseases, mental health, chronic alcoholism, and the health problems of air pollution and atomic radiation, we must still determine the specific nature and scope of the problem. The specific responsibilities of the official health agencies, of other community groups and of the individual citizens can only then be delineated.

Application of New Knowledge

Substantial progress in meeting some of these health problems is, then, largely dependent upon research. Responsibility for supporting and stimulating medical and allied research is shared by the Federal government, universities and other agencies. Individual States have the responsibility of applying new knowledge acquired by research and of developing the administrative patterns essential to its application.

For solution of the problems in which the responsibilities have been more positively delineated, continued attention must be focused on effective utilization of the available assistance from the Federal government. The continuing utilization of these resources and the application of the knowledge currently available are responsibilities of the individual States. In California these responsibilities are effectively shared by public and private health agencies, both State and local, by the professional groups and by the individual citizen.

Most of the health problems which have been discussed are not peculiar to California. Other States and many Nations are affected by such problems. National and international agencies and organizations can facilitate the exchange of ideas, can promote the adoption of health measures and practices of demonstrated merit, and, of paramount importance, can and must stimulate and support coordinated research in these fields. As in the past, we in California are ready to learn from others, and to share our experience with them.

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Bed Requirements

Commissioner RUSSEL V. LEE. Dr. Dyar, how many beds per thousand do you use for your yardstick for requirements?

Dr. DYAR. On an over-all State basis we use the standard established by the Federal government under the Hospital Construction Program, four and a half per thousand. Within the State, that varies from six and a half or seven per thousand in some of the metropolitan areas, to two and a half per thousand in some of the more isolated rural areas.

Commissioner LEE. On that basis do you make your 20,000 deficit, though? Was that the figure you gave?

Dr. DYAR. The 20,000 figure was the number of beds constructed since the end of World War II.

The deficit in total beds is approximately a third of the total need.

Commissioner LEE. There is a 33 percent deficit now, then?

Dr. DYAR. That is right, sir.

Accident Prevention

Commissioner LEE. I have another question. Do you think the Public Health Service should take over that accident prevention? We bump into that all the time. It seems to be a 13 billion dollar bill we pay for accidents now in the country, overall. Under what agency should that be placed?

Dr. DYAR. If I were to answer the question candidly, expressing my personal opinion, at the moment I would say no, we don't have the staff to do it. Right now the industrial health services in the State Health Department are practically hamstrung because we cannot find medical people for that job.

Theoretically, philosophically, public health takes a lot of know-how of prevention, and many of the public health agencies are already working in public health accident prevention programs. I am sure that I can speak for the Department and the other public health people in the State when I say that we shall be glad to cooperate in such a program.

Commissioner LEE. But you wouldn't like to have it handed to you now in addition to your other duties?

Dr. DYAR. That is right.

Statement¹ of

DR. JOSEPH G. MOLNER

**Health Commissioner, Department of Health
Detroit, Mich.**

It is but infrequently that in discussion of the health needs of a community or a Nation that reference is made to the more positive aspects of health. It is but rarely that reference is made to the tremendous amount of progress that we have made in the past half century.

It would appear that most everyone is looking with a critical eye at modern medicine and medical care and at whatever failings and deficiencies exist in medical care and modern medicine that differ internationally, in the United States, between States and even between localities and communi-

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

ties within such States. For example, most certainly the medical care problems of rural Michigan, or the Upper Peninsula, are much different from those which exist in metropolitan areas as, for example, the city of Detroit and County of Wayne.

Let us, however, look at our modern medicine from a cold, critical and factual point and examine some of the progress that has been made. To illustrate my point, let us examine the figures in the following table and compare the 1950 death rate from certain diseases to that of 1900.

<i>Death Rate</i>	<i>1900</i>	<i>1950</i>
General, per 1,000 population-----	16.3	8.3
Tuberculosis, per 100,000 population-----	131	30.6
Diphtheria, per 100,000 population-----	29.1	0
Typhoid fever, per 100,000 population----	28	0
Maternal mortality, per 1,000 live births--	25	.6
Infant mortality per 1,000 live births-----	213	26.8

What more vivid illustration will we need to point up the tremendous improvement in life saving over this 50-year period?

Rates are rather difficult for some people to understand, so let me further illustrate my point by the projection of the over-all death rate of 1900 to 1950. In 1950 there were 15,396 deaths in the City of Detroit. If the 1900 death rate had prevailed, 30,562 people would have lost their lives. We could project the specific death rates in much the same manner and even more definitely emphasize our points.

Antibiotics Make Medical History

Smallpox was a very prevalent disease claiming hundreds of lives annually, and now we haven't seen a single case of smallpox in over 7 years. These are but a few advancements which have been made. We could go on about other great advancements without the advantage of statistical support; for example, our advancements in the treatment of tuberculosis alone in the past few years, with modern surgery and modern drugs, is a fabulous story unto itself. The advent of the antibiotics and the control of such diseases as pneumonia has made medical history in these past few years.

There are problems in medicine and in health. We most certainly should not cover up these needs nor should we play ostrich with the problems that face us.

The Health Department of the city of Detroit has the privilege, in addition to rendering general health services, of operating three major in-

stitutions which house 3,300 hospital beds. These hospital beds are allocated to tuberculosis, communicable disease, obstetrics, general medical and surgical beds as well as psychopathic beds. We also operate a rather extensive and comprehensive home medical care program, a home delivery service and a tremendous out-patient service for all types of injuries and illnesses, including tuberculosis, venereal disease, dental conditions and drug addictions. We, therefore, have a rather extensive exposure of preventive medicine and of medical care.

Nurse Shortage

In the opinion of the writer, one of the major problems is the shortage of professional personnel, and, particularly, nurses. There are several factors involved in this shortage of nurses. There is a greater demand because of increased numbers of hospital beds and because of an increased expansion of industrial medical care programs. There is also the factor that not nearly as many young women are going into nurses' training programs as there used to be several years ago.

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Every effort should be made to increase the enrollment of new students into nursing. During the second World War, the Federal government subsidized nurses' training programs, and it is my humble opinion that some such program should again be initiated with some subsidy, because without it I am dubious that any increase in enrollment would result in spite of advertising and public-relations work.

We are faced with an ever-increasing shortage of registered nurses because of the tremendous hospital construction programs throughout the Nation and particularly in this area.

The practical nurse most certainly is here to stay and she is, with her limited training, rendering exceptionally fine patient care service . . . doubting Thomases must admit the practical nurse is today a tremendous asset in our medical care program.

Practical nurse training programs should be encouraged and the training of practical nurses accelerated. Further, we should study even more extensively the possibilities of reallocation of work associated with patient care to even greater extent, so that more responsibilities of such type can be allocated to the practical nurse.

Mental Hospital Beds

There is a shocking shortage of mental hospital beds. The crowded condition under which we are obliged to house and care for these most unfortunate people is certainly one of the greatest blights of Government and all medicine. One has but to visit the mental wards at Receiving Hospital to realize the magnitude of this problem. . . .

We have but to refer to Albert Deutsch's book entitled, "The Shame of the States." This book was published in 1948, and gives a rather vivid description of this problem. We have known that there has been an ever increasing incidence of mental disease. We know too that our methods of therapy are not too productive of good results, and consequently we should have known that a critical shortage of mental hospital beds was in the process of developing.

Regardless of sources of funds or methods utilized for reaching the goal of sufficiency of mental hospital beds, this must be done. The program of construction must be accelerated even though we are faced with the shortage of professional personnel, registered nurses and doctors, as the care of these patients will be considerably enhanced if we can bring about a reasonable reduction in crowding.

Hospitalization of Tuberculosis Patients

We have talked about tuberculosis and indicated that the death rate had dropped from 131 per 100,000 population to 30.6 per 100,000 population, with an expected five-point drop within the next year. But, the hospitalization of tuberculosis patients is still a problem, because there are insufficient numbers of beds.

I am ashamed to report that as of this moment there are 244 known cases of tuberculosis in the county of Wayne which cannot be hospitalized because we do not have sufficient number of beds for tuberculosis patients. Through a remodeling process, within 30 days we will have 88 additional beds and within 1½ years, through new construction, we will have 250 additional beds. It would appear from the statistics of reported cases that this represents just sufficient numbers of beds to cover our needs, provided there is no numerical increase or rate increase of this disease.

Preventive Medicine

We have made great advancements in preventive medicine, as can be verified by the very few statistics which have been quoted in this report, but

our preventive medical techniques must be applied now to other diseases. We are doing a considerable amount of research and experimentation on preventive mental health within our own Department. More can and should be done.

Mental hygiene is an intangible. It will be difficult to evaluate, and the productivity of such a program is probably years ahead of us. We must apply our preventive medical knowledge and our ingenuity; we must develop the teams of public health workers and psychiatrists who can help us develop techniques that might prevent at least some cases of mental disease.

This is but one of many areas into which preventive medicine must expand. We have but to name a few more; the prevention of cancer, heart disease, and prematurity which today contributes 25 percent to the total infant mortality rate. This is but one important phase and problem of prematurity, because we know from studies and actual experience that these premature infants, in many instances, pose medical and social problems. They do not develop as well as full-time infants, and certain development deficiencies become physical problems with these children, as, for example, blindness caused by retrolental fibroplasia.

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Advances in Industrial Medicine and Hygiene

There are continued improvements in the process of adoption that are rather extensive in our medical and industrial programs. Better pre-employment examinations, ascertaining the fitness of a man to a job and a job to a man, periodic re-examination and many, many other improvements to serve better the industrial worker in a preventive medical way.

The tremendous improvements that have been brought about through the activities of industrial hygiene are far too numerous to mention, but we should include improvements in ventilation which will result in the reduction of pulmonary irritations, industrial dermatosis and lead poisoning. There is still room for improvement in industrial medicine as well as industrial hygiene, and we are locally throwing our full force of preventive medical techniques behind industrial hygiene and industrial medical programs.

Putting Life Into Living

It has been said, and properly so, that "we have learned to save lives, but have we learned to save living?" Through preventive medicine and med-

ical programs, as previously indicated, there has been a tremendous savings in life expectancy and the savings of life in the younger age groups. But, have we kept concurrently abreast in the saving of living? There are many, many problems of an aging population, and in this area public health workers and the members of the curative arts have a tremendous problem. This problem must be faced if we are to take full advantage of the saving of lives.

One may not agree with reference to housing, but good housing is an extremely important factor in the perpetuation of good health. Housing has been a problem since time immemorial. Stephen Smith, in his first report to the New York City Board of Health a century ago, called attention to the housing problem. We can still find blighted, substandard housing and housing areas in most of our larger metropolitan areas.

Federal Public Health Aid

This Commission is familiar with the Federal government's grant-in-aid to States. These grant-in-aids to States have been established to promote public health services in needed geographical areas as well as to promote certain special phases of public health as, for example, venereal diseases and tuberculosis control. We, at a local level, are very much in need of this type of assistance, and particularly in those areas of preventive medicine which are in the process of development as, for example, the prevention of mental disease, prevention of cancer, et cetera.

We also are in need of assistance in those particular areas of public health which pose the major problems such as venereal disease, tuberculosis control and industrial hygiene. At the present time it is generally recognized that Wayne County has approximately 60 percent of the venereal disease and tuberculosis problem in the State, and yet we received only approximately 30 percent of the total allocation of tuberculosis funds to the State. Out of \$172,000 for venereal disease allocated to the State, we received \$11,000 or approximately 9 percent.

We have no quarrel with the State department of health or with any other governmental agency. We feel that the State department of health has done an exceptionally fine job in the allocation of these funds. They must necessarily look at the over-all problem, not just the acuteness of the problem in any particular locality, but at the prob-

lem as it may exist in some small population area that doesn't have the financial means of taking care of this problem however small it may be.

It is my contention that if grant-in-aid to States is to continue, certain large governmental agencies and health departments, much like the city of Detroit, should be able to apply to the Federal government directly and, on the basis of merit, such grant-in-aid be either granted or denied.

Statement¹ of

MR. V. M. EHLERS

Director

**Texas Bureau of Sanitary Engineering
Austin, Tex.**

The Southwest at this time is passing through one of its worst droughts in history, creating serious water shortages, causing agricultural and livestock losses, bringing with it rationing and the use of emergency questionable water supplies, impeding industrial development and creating public sentiment.

A program which would insure an adequate, safe supply of water for our ever growing cities and increasing number of residents of rural areas would greatly benefit the public health and public welfare of the people of the Southwest. Some water now used for domestic consumption, food processing, recreation, and even for irrigation or oyster growing purposes is not considered desirable or safe in all of its categories. It does not meet the national chemical and bacteriological standards.

A joint Federal-State river basin conservation program with the support of our people will replenish our underground reservoirs, minimize soil erosion and, through empoundages and distribution works, store and make available the water which is necessary for municipal, industrial, recreational and irrigational use, as well as eliminate public health hazards now existing in communities not able to finance community systems. The coordination of National and State water policies into a practicable and acceptable working instrument should not be too difficult to promulgate by the officials and the water works and engineering professions of the States in the Southwest.

¹Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

Stream Pollution Control

The Southwest has made considerable progress in the field of stream pollution control. Pollution of streams by oil field brines and industrial plant wastes constitutes one of our greatest threats. With the industrialization of the Southwest the additional burden that industrial wastes are placing upon the streams necessitates emphasis on the program in order to assist industrialists in the solution of their problems, so as to conserve our reserves for present and future use.

For some of these wastes no practical treatment has yet been found. Further investigations are required of some of our streams, and research is necessary to study those particular perplexing wastes for which no economical method of treatment has been established. The withdrawal of Federal water pollution control funds leaves the State Department of Health in an embarrassing dilemma.

Through funds that were made available by the Public Health Service, a marked reduction of the incidence of malaria and typhus fever has been attained. This activity should be financed in the future by the State in order to prevent a recurrence of the high rates of infection which are likely to result with the further reduction of Federal funds. They are practically withdrawn at this time. I might add here that at one time we had estimated 100,000 cases of malaria in this State. These have been brought down this year to less than 500, but we see nothing on the horizon at the moment which will enable us to hold the line.

Cooperative Demonstration

Dysentery and diarrheal diseases are among the leading killers of our young children in the Southwest.

Cooperative Federal-State-local demonstration projects to control the spread of fly-borne dysentery have been operating in several southwestern States for the past 3 years. These demonstrations have been highly successful in improving local practices and raising the standards of environmental sanitation throughout the entire area.

The concept of improved sanitation by actual demonstration should be intensified and enlarged, and scientific investigation into the vectoring po-

tential of flies, roaches, mosquitoes and the like should be accelerated.

Slum Clearance and Housing Hygiene

The demonstrations of low-cost public housing, pioneered by the Federal government, have fully shown the possibility that lies ahead with slum clearance and the promulgation of hygienic housing. Public health departments have been lax in interesting themselves in housing and should be urged to assume the responsibility of pioneering housing sanitation through urging the adoption of proper housing ordinances, but, more especially, in the promotion of housing having minimum facilities for safeguarding the health of the occupants. It is believed that local finances are available in many of the southwestern cities, and furthermore, that local realtors will accept and provide housing meeting practical hygienic housing principles prepared by the health departments.

The development of the outer fringes of some of our municipalities without proper planning presents many public health hazards. These hazards are largely due to the lack of planning of this phase of sanitation and zoning, which is of importance to local and State health departments. These areas must be placed under sanitary control in establishing a comprehensive and effective public-health program.

Air Sanitation

... Industrial health programs have been lagging and have not received the consideration here in the Southwest to which they are entitled. Many complaints—hundreds—a petition of 5,000—have reached our Department from the inhabitants living near certain industrial plants which have been discharging pollutants into the atmosphere. The awakening of the residents to the fact that their right to expect clean air to breathe is being usurped is increasing the urgency for a complete solution of this problem. In order for the health departments to keep in step with this problem, some aid must be immediately forthcoming if the State is to continue to progress.

Standards for New Products

The entire field of frozen food, food packaging and food automatic dispensers should be appraised from a public health standpoint, and standards should be developed covering these new products,

their processing and packaging. Through cooperation with industry, a desirable plan for control can be formulated.

The need for adequate training programs in public health and allied fields is more apparent at this time than ever before. The ever-increasing demand for full-time health services, together with new problems presented by industrial and domestic developments have created a shortage of trained public health personnel which must be alleviated if we are to continue to give public health protection to our people.

County Health Units

In the State of Texas, the residents of only 57 counties are being served by full-time county health units, leaving 197 counties without adequate health services. The greatest need for improving health in rural areas is a staff of specially trained personnel to disseminate knowledge on protection of water supplies, proper sewage disposal practices, insect and rodent control measures and all other phases of the public health program. More adequate personnel is needed in county health units so that environmental sanitation programs in rural areas can be expanded to meet the present existing needs. A comprehensive rural health program under the supervision of public health authorities must be provided and coordinated with other agencies now dealing with the rural problem.

In populated areas outside of corporate limits of municipalities, the legal machinery must be set in motion so as to enable residents to organize and to procure community type water and sewerage facilities, insect and rodent control programs, garbage collection and disposal, and to solve their other health problems.

Our mortality and morbidity rates are high along the Texas border. Quite a number of diseases have crossed the border into Texas. This border problem requires special treatment in which our National Government should assume more of its responsibility.

The Institute of Inter-American Affairs has assisted in improving some of the border water supplies and in training some personnel, but the need for pollution, malaria, typhus, typhoid, dysentery control is urgent.

Statement¹ of

DR. CARL N. NEUPERT

State Health Officer

Wisconsin State Board of Health

Madison, Wis.

The principal unmet health needs in our State are not in the area of the care of those ill, but rather in preventing people getting sick so as to reduce the load of disability and dependence due to illness. Most people still do not know what good health is and how to attain it, in spite of all that has been done to get that information to them.

The fundamentals of what to eat for good health—nutrition, if you like—the hazards of overweight, early recognition of cancer and the other chronic diseases for which we have effective measures for eradication or alleviation, are among the more important of these.

There is so much that is known about them that is not appreciated or applied, or of which the individual is not aware, that, if it were applied, it would change the whole picture.

"Health education" we call the remedy, for want of a better term. Voluntary health agencies are doing a good job of health education, each in his field as far as it goes. There is need for a step-up on the part of official health agencies to round out the job. However, appropriating bodies—local and State—are so occupied with current, more dramatic problems in other fields that funds for this less tangible, though essential, activity are usually meager. As we let the need for caring for health neglect pile up, there is more and more necessity for private and public expenditure to meet it, not to mention needless suffering and death.

Important Health Problems

There are important health problems for which we have but a small part of the answer. Heart disease . . . cancer . . . the chronic diseases of the aged . . . poliomyelitis . . . come to mind. Though we're working at them through recently stepped-up research in our State and in the Nation, increased efforts in research to find answers are fully justified.

We here are aware of outbreaks of virus infection, gastrointestinal infection and others in com-

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

munities where the need to study them is immediate, if an answer is to be found, and so far we have been unable to get at them for lack of funds to do the job. It is a State responsibility that has been recognized in part through the building of a new laboratory that is nearing completion. We can hope that the need to take the next step will be recognized in the near future.

In Wisconsin we have done well in reducing to the point of practical elimination those communicable diseases for which there is a known preventive. This has been done by getting acceptance of the responsibility for protection on the part of parents and individuals, together with the splendid cooperation of the private practicing physicians.

Reducing Childbirth Hazards

Deaths of mothers in childbirth have been reduced to a minimum—there were but 42 mothers who died in childbirth in the whole State last year, associated with the birth of nearly 88,000 babies.

However, we still have a significant problem in the number of infants who die soon after birth and in the number of those born prematurely. We're working on the problem and have the active interest and cooperation of the physicians of the State.

Mental Break-Down

Others have undoubtedly brought to you the increasing problem of mental health break-down involving need for better facilities for treatment and earlier recognition of the mental illnesses.

Permit me to stress the importance and need for early recognition of behaviour problems and emotional disturbances of children in the interest of preventing them from crystallizing into mental illness.

During the past 10 years, our Department has been stimulating communities on a county-wide basis to recognize the problem and organize child guidance workers, and others refer children with emotional problems to this center where the problem is treated as an integral part of growth and development of the child.

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Hospital Facilities

While acceptable hospital facilities are now available pretty generally in the rural areas, thanks largely to the impetus of the aid—financial and otherwise—through the Hill-Burton Act,

there are still overcrowded hospitals in some of our larger cities, and the need for facilities for caring for older people, those with chronic diseases requiring less constant medical and nursing care, and for psychiatric patients, is less adequately met.

* * * * *

Trained Personnel Needed

The need is for trained health educators locally employed, with the assistance of at least one consultant on a State level. When citizens, farmers and city dwellers, get together to go into these matters, things usually happen for the good.

The shortage of trained public health personnel, especially physicians and nurses, obtains in Wisconsin as elsewhere.

Four of the 11 full-time city health departments currently have vacancies in their medical directorships. We have similar vacancies in two of our districts. Status, that is, recognition of the value of this type of work, and income differentials are the chief drawbacks.

Full Time Health Departments

Finally, may I elaborate a bit more fully on our need to have competent full-time official health departments on a county or multiple county basis to insure the carry-through of needed preventive public health services?

We have such services fairly adequately available in our 11 larger cities, and in our only city-county health department at Eau Claire.

The rural areas and the smaller cities have part-time health officers, one for each town, village and city, totaling nearly 1,800 in all.

The State board of health is charged with overall responsibility for the health and life of citizens, including the power to intercede if a local board of health fails to meet a health emergency.

In each of the Board's nine district offices covering the State, there is a trained medical health officer, at least one trained public health nurse and sanitary engineer, a nutritionist in several, a drainage basis engineer in most, varying numbers of sanitarians enforcing hotel and restaurant regulations, plumbing regulations, and others.

Local Public Health Coverage

The Board has been quite successful in the elimination of communicable diseases for which there are specific preventive measures and those responding to sanitary control. As a result, small-

pox, diphtheria and typhoid fever are virtually nonexistent.

However, as we face the health problems associated with the aging of our population, the set-up promises to be inadequate.

The chronic diseases, especially heart disease, cancer, diabetes, et cetera, can be reduced most effectively through individual recognition of the need to get medical attention early.

Public health nurses are effective, through home calls, in motivating people to act. Further refinement in sanitary control that would further reduce the load of illness requires more concentrated and, therefore, more local attention than is possible under our centralized but thinly covered district set-up.

The answer, as we see it, is coverage with local full-time health departments. To spread the cost sufficiently to carry the financial load, the basic unit should have a population of 50,000 to 100,000 as a minimum.

In our State this means county, city-county, or multiple county health departments.

Some of our communities, if not all of them, could eventually foot the bill. To help them get started outside financial aid appears necessary.

A State aid bill has failed to pass the legislature. Federal aid with safeguards so as to insure local control would be helpful. The State board of health is on record favoring such a Federal aid as an immediate catalyst.

Statement¹ of

DR. ALBERT E. HEUSTIS

State Health Commissioner of Michigan
Lansing, Michigan

The records of the Michigan Department of Health, in the printed material, will show that Michigan's health status is the best ever. It will show, also, that there exist many things of which we may all be proud. It will show, too, that working together—official health agencies and almost every single one of the groups that I have heard so far this morning—is the real key to the success of the whole program.

All of these things are a source of great satisfaction. But to my way of thinking they should give us absolutely no sense of complacency at all, because in spite of all these good things, there is a

good deal to be done. The report shows the tremendous increase in the population of the State, 21 percent of the general population and some 53 percent of those under ten.

The present public health services that are available in Michigan are simply not adequate to meet the sheer demand that this increased population provides. I would point out particularly, too, that while the labor force has, as a whole, increased some 17 percent, those in manufacturing in Michigan have increased 35 percent. I should compare the comparisons since they are for the past 10 years.

Air Pollution Problems

The number of manufacturing plants in Michigan has increased by 6,000 in these last 10 years. They are also using newer materials and more effective materials, some of which are more toxic. They are using radioactive materials and high voltage X-ray to an extent never before contemplated. The air-pollution problems both within and without the plants are causing serious concern.

The Michigan Department of Health and Public Health people do not believe that the entire answer is improved public health service by any means, and neither do we believe that the entire answer to anything I shall talk about is improved public health service. But one very important phase of the answer is improved public health service.

I think it is interesting to note that with the maximum use of the technical personnel now available to serve industry we can reach only 13 percent of the plants each year. The problems of the older folks have been pointed out. There has been a 37 percent increase in the past 10 years of those over 65. This increase in longevity has put diseases such as cancer, heart disease and diabetes up to the very top of the list. It is interesting to realize that those three diseases caused more than half the deaths in Michigan in 1951. The same death rate is expected in 1952.

New Methods Necessary

We believe we have got to develop new methods to handle this problem; that we must discover more facts than we now have concerning the incidence of these diseases. We have got to apply this same disease investigational method. We have a fancy term called epidemiology, but we have got to apply to these newer problems the

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

same disease detectional methods that worked so well in handling some of the older ones. We have a variety of other problems, too. Regarding sanitation, the facilities that were adequate for the one family, or a few, are wholly inadequate or impossible when the population increases a hundred-fold.

Specific Health Problems

Tuberculosis, which was the most expensive communicable disease in 1951, will in spite of polio continue to be the most expensive in 1952. Over two-thirds of the admissions to our tuberculosis sanitariums are patients in the advanced stages.

I would point out to this Commission and to the folks that are here that the provision of beds alone will never lick the problem of tuberculosis. We have got to have better case-finding. We have got to have more prompt hospitalization. We cannot forget about the patients when we discharge them from the hospital. There must be provisions for more adequate follow-up and rehabilitation, as we have heard before, concerning other things.

Venereal disease is still a problem, second only to tuberculosis as the cause of death from communicable diseases.

Accidents and especially home accidents—a field in which we know the answers—here in a Michigan community we have demonstrated that the death rate from home accidents can be reduced significantly.

In nutrition, so many of us thought that perhaps aging was synonymous with degeneration. Applying effectively the knowledge which we already have, as one of the previous folks said—the effective application of this, we believe, can do much to get rid of that disillusionment.

I would like to mention briefly blood and blood problems. We need more solutions than those we have. We need research, not only for materials to prevent and treat diseases, but also research into the public health methods we are using today.

I mention disease investigation—some of us think that as tools we need no more than the tremendous pictures that we can show on slides.

I would call to your attention the fact that although the death rates from infant diarrhea has made a remarkable decline, the number of baby deaths this year was larger than ever before. Polio is not licked and neither is dysentery.

Health Education

I would like to remind you folks that in my opin-

ion perhaps the greatest need of all has been touched upon by some others. I refer to health education. We have the facts. We have the facts to do twice as much, in my opinion, as we are now doing. We must add these facts to the additional knowledge and the research, and put them at the disposal of personnel that can make effective use of them.

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Local Public Health Departments

Those of you who have heard me before know I never talk about full-time local health departments, unless I put a whole string of adjectives in front of it. They must be adequately staffed with full-time personnel. There can be absolutely no compromise with part-time personnel in local health departments. The doctor has to choose between taking care of the man's broken leg today or preventing the typhoid epidemic tomorrow, and I am that doctor. I will fix the leg.

The personnel in local health departments should be locally responsible. They should be locally controlled. They should be, as far as possible, locally financed. I am interested in health. I am interested in productive life but I am interested in money, also.

I would point out to you that with regard to the diseases we hear about in the Health Department, it costs much less to prevent those diseases than it does to treat them; and with many diseases such as tuberculosis it costs much less to treat them if we find them early than it does if we find them late.

Statement¹ of

DR. JOHN D. PORTERFIELD

Director

Ohio Department of Health

The Ohio Department of Health, in addition to its workaday duties, has devoted a large amount of time to contemplation of the detailed and complex problems of the health status of Ohio citizens.

It has done this from the vantage point of close experience with many of those problems and of close association with other bodies concerned. . . .

Opposed to this advantage of intimate appreciation of the problems is the difficulty which the

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

Department suffers—with serious lack of funds, of qualified personnel and of time in developing accurate articulation of the experience endured and observed.

Within these limitations an attempt has been made to list the major problems, to define some of them, and to suggest possible solutions where these are discernible.

Major Health Problems

- These are Ohio's major health problems:
1. Insufficient number of properly trained and qualified health personnel.
 2. Inequitable distribution of what health personnel are available, thereby enhancing the shortage in certain areas.
 3. Inadequate facilities for the care of the sick, the dependent and the domiciliary cases.
 4. Inadequate governmental appropriations for the provision of reasonable community health and preventive medicine services—and a cumbersome taxation system which hinders the development of adequate local funds.
 5. Inadequate knowledge on the part of the public of the need for good community public health programs.
 6. Excessive national promotion of a superficial solution for all health problems.

Personnel Shortage

From the point of view of public health, qualified personnel shortage has been a serious problem for at least the last 10 years. This applies to almost every category of professional discipline in the public health field, with physicians and sanitation personnel as the classes with the greatest shortage.

It extends, however, to public health nurses, to trained public health administrators, to statisticians, health educators, nutritionists, and public health laboratory workers. The personnel shortage is, of course, affected by what may be considered the usual drain of military requirements over the past ten years, but even in a period of lessened military activity this shortage would exist.

You have heard and will probably hear again discussion of national shortages in the number of physicians, nurses and other categories. This shortage is intensified in public health because an inadequate percentage of those in the professions choose public health as a specialty career. Inadequate financial return compared to other specialties is, of course, one obvious reason. But another

almost equally important factor is the previously low prestige of public health personnel. Such people are employed by government and are therefore associated with elected officials. When political people are venial, their reputation is extended to public health employees—sometimes, sad to say, properly but often unfairly.

There is in Ohio an increasing interest in and usage of community health services. One of the major obstacles to improvement is this personnel shortage, and Ohio, like the Nation, has from 8 to 19 percent of currently budgeted public health positions vacant through lack of qualified applicants. The answer to this problem would seem to be to improve the reputation of public health people—which only they themselves can do by their actions and records—to improve their financial remuneration—and this is very slowly taking place—and to provide adequate training facilities for the specialty.

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Distribution of Health Personnel

The inequitable distribution of health personnel available is not as large a problem in the public health field as it is in the basic professions. There is a reasonable distribution of public health specialists which is influenced to a large extent by ability and willingness of local government to pay the market price.

Many of the smaller local governmental units are discovering that they obtain better quality of public health service in the quantity required by joining with their neighbors in local health units large enough to be efficient but small enough to meet the specific needs of the local areas.

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Community Problem

We, all of us, are sure that we know best how to run our own household and, while under the proper persuasion we may seek outside expert advice, we are very much inclined to resist that which is thrust upon us uninvited. Part of this difficulty is engendered by the more aggressive and the more radical aspects of national health propaganda. In addition, community citizens are frequently confused by one pat proposal to provide the cost of medical care from tax resources as a solution to all the facets of the health problems of the Nation and inevitably oversimplify their feeling by being "set against socialized medi-

cine," including in their definition all administrative medicine.

It seems most fitting and proper to me that there be a Commission to study the health needs of the Nation. It is very proper that we have such regional public hearings as this to discuss these problems and to bring more sharply into focus in the public eye their nature and extent.

It seems to us, however, in the Ohio Department of Health that the solution to the majority of these problems lies more in the hands of the communities and of the State than elsewhere. I am convinced that national solutions are too often more expensive, are almost constantly too standard, and are inevitably less well received than the self-reliant action of the crossroads of our country.

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Salary Range

Commissioner RUSSELL V. LEE. Doctor, what is the salary range of public health MD's in this State?

Dr. PORTERFIELD. In the local Health Departments in Ohio, the range is from \$3,600 to \$11,000 with the average around \$6,500.

Commissioner LEE. What would it take to make the position more attractive.

Dr. PORTERFIELD. More than just money: I think if the salary range was raised, we would only rob Peter to pay Paul. We would steal from some other places which could not pay as high. Prestige, I think, is part of it.

Finally, I think the challenge of a job worth devoting your interest to would be important. In Ohio, unfortunately almost half of our health department takes care of populations of less than 50,000 apiece, and there is no such professional opportunity.

Commissioner LEE. We have had from everywhere the statement that we have had public health positions going begging. Have you any suggestions to improve that situation?

Dr. PORTERFIELD. A long-range answer would, of course, be to provide more of the basic health personnel.

Student Aid

Commissioner LEE. Would you favor aid to students for training in public health school?

Dr. PORTERFIELD. No, sir. I would not like to buy a person's choice of specialty during the time

of his basic training. I would like him to choose it as a natural choice.

Commissioner LEE. Do you think it would be more likely of success if you gave him money to spend on the program than more salary for the man?

Dr. PORTERFIELD. I know of a considerable number of instances where that has been done.

Commissioner LEE. Do you have any positions you cannot fill now?

Dr. PORTERFIELD. Yes.

Commissioner LEE. What do you think of the proposal of Federal Aid to Local Health units?

Dr. PORTERFIELD. I think the principal trouble there is the same trouble that has applied to all Federal Grant-in-Aid Programs in public health. This is the cart following the horse to some extent. We have been given aid over a considerable period of years for special programs in cancer, heart, VD, and so forth; now they propose to help generalize public health. It should really have come first although I realize it was difficult to promote.

I think it would be a good idea on the condition that Federal assistance was not a major percentage of the support of the local health unit.

Commissioner LEE. In Ohio these local health units, are they truly local or are they State units?

Dr. PORTERFIELD. In Ohio they are truly local in that the State law has established the development of local health districts which are autonomous, except they must conform to the minimum standards of the State Public Health Board.

Source of Funds

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Commissioner LEE. Do they get money from the State?

Dr. PORTERFIELD. The major part of local health department money is from local taxation, and there is an extremely small token amount of State subsidy which has no qualifications or requirements. It is a reimbursable type subsidy and the appropriation is at a level which gives any health department a maximum of something like \$1,500 to \$1,600 a year.

The Federal grants-in-aid which are devoted to local health departments are given on more of a qualification basis, but still are about 10 percent of the amount of local money spent.

Statement¹ of
MRS. O. N. RICH
Public Health Educators Association
Raleigh, North Carolina

During the marked awakening of the South in the past 2 decades, and especially in the last 5 years, there has been much planning for meeting the health needs. Great advances have been made in hospital construction, voluntary health insurance programs and health information programs. These have had favorable impact upon our way of life, but we know that we cannot claim that the people of the South are conspicuously healthy.

As we plan for new facilities and programs and the personnel to man them, we must recognize that many of our people are failing to make use of facilities already built and programs already in progress. For example, mass tuberculosis X-ray service, cancer detection clinics and maternal and child health clinics and health departments in many instances are not patronized by the part of our population needing them the most. Many people who have even been persuaded to buy hospital or health insurance are not seeking treatment when they are sick.

These are but a few examples of poorly utilized resources. It is apparent that there are marked gaps between what is known and what is done, between what we have to do and what we are doing.

The North Carolina Association of Public Health Educators, Inc., and the South Carolina Society of Public Health Educators submit for the consideration of the Commission this suggestion, that the gaps can be more nearly closed when many more of our people are brought into the planning and the carrying out of the health programs. The people who need to be reached and served, as well as accepted community, county and State leaders, must have a voice in the judgments and a hand in the action.

Community Organization

The opening of opportunities for better citizen participation and action cannot be left to chance. It requires community organization. Real community organization is based on the principle that what enough of the people want and get for themselves, they will use and support. Health educa-

tors along with workers in allied professions believe in and foster community organization.

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Wherever employed, health educators have shared in significant results when people and communities have awakened to their opportunities and have acted together. There is one town in Person County, N. C., where the people found the way to overcome their sanitation problems; Spartanburg, S. C., where the citizens studied possibilities and took action for community health; Hillsboro, N. C., and Green Sea, S. C., where school health programs gave impetus to community-wide health improvement; Alexander County, N. C., where a hospital was constructed and maintained by the people, and where a new pattern of community participation began to emerge; Chatham County, N. C., where, after the rural Negro population became aware of their unused resources, they moved ahead to improve roads, secure a farm agent, extend health services, attract a doctor, improve their homes, and provide sound health information to the rural population. . . .

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Community Planning

Health educators do not assume sole credit for these significant unfoldings in community organization for health education in our States in the South. They have succeeded as they have served as partners with other professional workers and with the people.

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These trends and developments have not resulted from the dispensing of mere health information. Health education includes giving information, but it is much more than the distribution of leaflets and more than publicity and public relations. It is the process of guiding public action into paths already lighted by scientific knowledge. It is the business of changing health behavior. It is the work with the people to help them attain health as defined by the World Health Organization.

The demand for health educators far exceeds the supply. Less than 50 percent of actual requests are not being met in North and South Carolina, and as we look to any sort of ideal situation, we are far below what we would like. The goal set by the American Public Health Association is one health educator per 9,000 people. That would require for North Carolina 450 health edu-

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

cators, and for South Carolina, 223. At present, we have in North Carolina 68 and in South Carolina 21.

If we are to meet the goal within the next 15 years, we will have to train 30 people each year in North Carolina and 20 in South Carolina. . . .

Statement¹ of

DR. A. C. OFFUTT

Indiana State Board of Health, Indianapolis, Ind.

The health problems which exist in Indiana today cannot be solved merely by the provision of additional facilities and personnel. Good health cannot be forced upon people. When they are educated to the advantages of good health, people will work to secure these benefits to themselves, their families, and their communities.

Indiana is proud of the record it has achieved in preventing disease and disability and in prolonging life. Our morbidity and mortality rates compare favorably with the Nation's average. Maternal and infant mortality rates are good indices of the health status of a State. Indiana ties for fourth place in the maternal mortality rate in the Nation. Our rate is 0.6 per 1,000 as compared to the national average of 0.8. Indiana's infant mortality rate is 27.0 per 1,000, placing us 24th among the States, the national rate being 28.8.

The lag which always exists between the discovery of knowledge and its application presents a problem which can be solved. We have never been satisfied with just doing a better job than other States; we will be satisfied only when we have achieved that which Indiana is potentially capable of accomplishing.

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Full-Time Local Public Health Services

Public health needs occur among people in local communities. The most effective and economical method of meeting these needs is the provision of public health services by qualified full-time professional personnel responsive to both local needs and direction. Indiana has 180 local health jurisdictions; 10 of these are under the direction of a full-time health officer and serve 29 percent of the population. One hundred seventy local

health jurisdictions, affecting 71 percent of the population, are served by part-time health officers, most of whom function without additional staff. Six of the full-time local health department have been established in the last 6 years.

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Personnel

Personnel losses in the State Board of Health have seriously affected the quality and quantity of services to the people of Indiana. Five physicians, directors of major programs, have resigned to accept positions in other States primarily because of greater compensation. Fourteen experienced engineers have accepted positions with industry and private consulting firms. Losses of personnel in health education, nursing, laboratory and other professional categories have occurred. A few replacements have been secured, but these have lacked work experience for which there is no substitute.

It is poor economy for Indiana to educate and train professional personnel and then lose them to other States when they have become valuable public servants.

Our employees do not receive other benefits comparable to those in industry and surrounding States. A program director in our agency retired on September 1, after 35 years of service. His retirement compensation is \$62.00 a month.

More professionally trained people are required. But equally, if not more important, Indiana must provide compensation and retirement commensurate with training and experience, if it is to secure and retain well-qualified personnel.

The same situation prevails in local health departments. One well-organized full-time health department has been seeking a qualified health officer for 2 years.

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Specific Problems

As must be true in other States, we are confronted with many specific problems. Time will permit me to mention only a few of the more important of these.

A. A continuing study is being made of the specific health problems associated with old age. The increasing percentage of the high-age groups in our population, brought about by the continual increase in length of life, has resulted in a rapid growth of health problems in this age group. Institutions and programs designed to care for

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

the aged are being critically appraised as to their purpose and worth. Foremost among these is the County Home, which may well have outlived its purpose as originally delineated. Findings in these studies are being analyzed for the purpose of developing a State-wide program to meet the needs of our present-day society.

B. The State Board of Health is studying the problems associated with chronic disease, such as diabetes, cancer and heart disease, and initiating measures directed toward relieving these problems. . . .

C. With greater industrialization of our cities, atmospheric pollution problems are becoming more acute. Such pollution can create hazards to health. Steps are being taken to develop a program designed to reduce this hazard to a minimum.

D. Commendation is due Congress for the enactment of Public Law 725, which provides funds to aid in the construction of hospitals and health centers. In addition to aiding local communities . . . several desirable principles were established:

1. The program was primarily one of State-local relationship.

2. Construction was based upon the need as determined by a State-wide survey and plan.

3. No control over the facility by either Federal or State Governments after construction was completed.

Indiana has acquired and is now using 892 hospital beds under this plan. An additional 842 beds are under construction or are planned, assuming Congress continues to authorize the annual appropriation through June 30, 1955. This is a splendid program and might profitably be continued after 1955.

During that same period there were some 1,500 other beds put into service in Indiana which did not come under that law.

E. Animal diseases transmissible to man are important in Indiana, since a major part of our economy is in the area of dairy, swine and cattle production. Brucellosis, tuberculosis, rabies, and more recently anthrax, are among the most important of these diseases. Dramatic progress has been made in the eradication of tuberculosis in cattle, with a resultant decrease in human bovine tuberculosis.

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Indiana's major problems in public health lie in three general areas: Public education, local

public health services and personnel. We have not yet solved all of the specific health problems that exist in relation to hospital facilities, chronic disease, care of the aging population and air pollution.

Additional facilities and personnel are part of the answer; however, of greater importance is a thorough cooperative effort in devising methods and procedures to secure more effective utilization of existing resources.

Statement¹ of

DR. HAROLD J. KNAPP

City Health Commissioner

Cleveland, Ohio

Just a half century ago morbidity and mortality from communicable disease was appalling. Acute communicable diseases in the main now are under control in this metropolitan area. In spite of these advances, however, communicable disease must still remain an important function of a health department.

Modern transportation facilities have made an outbreak of communicable disease anywhere in the world a potential hazard to any community, including this metropolitan area.

Successful control measures of the past must be maintained and new procedures for the control of other diseases improved and applied as knowledge is gained concerning their ideology and method of transmission.

The ultimate goal of public health is not merely the prevention of disease and the institutional care cases of disease, but the positive promotion of physical, mental, and social well-being. Inadequate housing, chronic illness, mental illness, prematurity, inadequate sewage and water distribution facilities, and shortage of trained professional personnel are some of the major threats to the well-being of a community.

Housing

Locally housing has become a major health problem. This is true in many large cities and metropolitan areas and the Cleveland area is no exception.

Locally there are thousands of substandard housing units in which a considerable segment of our population of necessity lives or at least exists in deplorable conditions.

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

Basic planning for housing is the responsibility of planning commissions, but every unit of local government must share in some phase of this activity, and every citizen is affected by the results.

Physical, mental and social health depends to some degree on satisfactory housing. The rate at which housing units are now being constructed locally, however, throughout this area, if continued for a few years, should result in an excess.

When this goal is attained housing and building departments in cooperation with planning commissions will be able to do much in the elimination of dwellings unsuitable for human habitation.

* * * *

Hospital Insurance

Approximately 70 percent of the population in Cuyahoga County are covered by hospital insurance and a considerable proportion of them are covered by medical insurance.

This excellent coverage has important ramifications in the control of chronic illness. As we all know, early treatment of acute illness often prevents the development of chronic illness.

Also early detection and treatment prevent the disabling complications and hasten adjustment to life with the illness.

The popularity of individual hospital and medical insurance is attested by the increasing number of participants in this area. This metropolitan area is one of the best in the Nation as regards individual medical and hospital coverage.

Mental Illness

Many of the authorities in the health field consider mental illness the major health problem as yet unmet. The hospital needs alone for meeting this problem, and present inadequacies are obvious. The preventive approach to the problem is overwhelming and is dependent in large part upon vigorous and basic research. This will mean expenditure of substantial amounts of money, but I believe that such expenditures would pay real health dividends.

Prematurity

Prematurity is now the greatest single cause of mortality among infants.

Premature infants are more likely to have developmental defects which may handicap them throughout life. Reduction of prematurity depends upon being able to bring about early care at the hands of a highly skilled medical profession.

Reduction of prematurity thus depends upon specialized nursing and hospital facilities. An official health agency must keep abreast of the newer medical knowledge in this field and through educational and service activities stimulate the public to take advantage of it.

* * * *

Personnel

Now I consider that this is probably one of the major problems. Locally, nationally, internationally, shortages of health personnel in all categories are a major deterrent to health progress.

Salary and wage inadequacies in career positions in the field of public health and teaching institutions for professional workers are important deterrents to recruitment. There must be an increase in the output of trained medical and public health personnel.

Present training facilities must be extended and improved and made more readily available for training of personnel.

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Commissioner ELIZABETH S. MAGEE. Do you have any suggestions as to how to solve the problem of personnel?

Dr. KNAPP. I do not think that it necessarily means the increasing of the schools of public health, but rather I think it means the increasing of facilities of all types of institutions training people for work in the health field. I do feel that the 13 schools of public health are probably reasonably adequate to supply a certain type of administrative personnel. I am thinking about groups such as health educators, health officers and engineers for the post-graduate training work.

Federal Aid

Commissioner RUSSEL V. LEE. What do you think about Federal Aid for local public health units?

Dr. KNAPP. I think Federal health aid, of course, is desirable probably in research and in training of personnel.

Commissioner LEE. Not for the subsidizing of these local units where none exist? There was a bill up for that in the last Congress.

Dr. KNAPP. I think that is basically a State function.

Commissioner LEE. What about these various screening studies by public health departments?

Dr. KNAPP. That is a good example of an educational approach. Probably up to the time these

were carried on we probably had the largest screening project carried on here in the Cleveland area in 1949. Then this year we have had a follow-up in areas where the incidence of the disease was high. That is an example of a cooperative program with local health departments.

Cooperation of Local Medical Profession

Commissioner LEE. Does the local health department have good cooperation from the local medical profession in those screening programs?

Dr. KNAPP. The medical profession took leadership with the local health department in that the chairmen of the important committees were covered by the local profession.

I should like to emphasize here that Cleveland is one of the pioneer cities in the health council type of operation and for many years our activities have been closely coordinated.

Commissioner ELIZABETH S. MAGEE. What was that screening? Was it just for tuberculosis?

Dr. KNAPP. Tuberculosis and other chest pathology.

Accident Prevention

Commissioner LEE. What about the responsibility for accident prevention? We find the No. 1 cause of death in children is accidental death. Should that responsibility for accident prevention programs be put in public health departments?

Dr. KNAPP. I think it well could be. I can comment on activities that have been going on here in Cleveland, largely an educational program in which the safety council works very closely with the health departments in the area.

Commissioner MAGEE. Mr. Lanpher, did you have a comment?

Tuberculosis Survey Work

Mr. LANPHER. I would like to comment on the survey work being done in tuberculosis. I think one of the original programs in the nation to do that originated within the hospitals in Cleveland, and at the present time there is a committee working with the problem in establishing survey units in every one of the Cleveland hospitals.

This is being financed by grants from the city, from the county and from the Anti-Tuberculosis League. And we hope very soon to have every hospital equipped to do chest surveys on every admission, not only on tuberculosis but for the other complications of chest disease. We think

that will be accomplished almost 100 percent within the very near future.

Dr. KNAPP. I am very sure, Dr. Lee, that Mr. Lanpher mentioned that because it is one of the current jobs right at hand.

Commissioner LEE. Your health council has been famous as the agency for that sort of thing. I think it is a good example of what can be done.

Statement¹ of

DR. J. E. SMITH

Health Commissioner, Department of Public Welfare, Division of Health

St. Louis, Mo.

The necessity for efficient personnel administration assumes major proportions, because in the public health field a very large share of the total funds is paid out in wages and salaries. The quality and quantity of health services are strongly affected by the caliber and morale of the people providing the services. Professional, technical and administrative personnel in the public health field have been traditionally and historically underpaid. The taxpayer always gets a bargain when a competent person is hired.

Any false economy with respect to the health of the people of St. Louis is costly—it is costly to every citizen, to every family, and to every industry located in St. Louis. The cost of public health pays enormous dividends: in lives saved, in suffering halted, in comfort and happiness, and in actual dollars and cents. The city of St. Louis can make no better investment than in preserving and promoting the health of all its people. It has been truly said that "Public Health is Public Wealth."

Inadequate Salaries

In view of the record of failure of the health division during the past 25 years to keep abreast of the modern public health movement, one may reasonably ask what are the factors responsible for our present situation.

In my opinion the most important factor in our inability to fill key medical and other professional administrative positions is the utterly inadequate salaries at the professional and technical levels in the health division, as well as in other units of our city government. Adequate salaries for

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

professional and technical personnel are the "sine qua non" of the future existence of the St. Louis Health Division, if it is to carry out its charter responsibilities of protecting and promoting the public health of its people. The situation has been most critical for some years now and is constantly getting worse.

Programs on "Crises" Basis

The all important medical and nursing programs have operated on a "crises" basis for the past several years, and during the past few years our laboratory and environmental sanitation programs, which have been superior programs, are gradually disintegrating into the same pattern. We are constantly losing trained and experienced personnel to other official and nonofficial health agencies and to private enterprise because we are unable to compete with the salaries offered by these various agencies.

In many instances the city of St. Louis has spent considerable sums of money in training these persons. From a purely economic consideration this is most unwise. Looking at it from the more important aspect of losing highly trained and experienced personnel who are familiar with the many facets of the various public health problems of St. Louis, it is deadly.

The solution to the salary problem lies in abolishing the \$10,000 ceiling placed on the salary of all city employees in the 1914 city charter under which the city government now operates. The 1914 city charter states that "no salary under the city shall exceed \$10,000."

Public Health Is Purchasable

In this connection it seems to me that in the science of government, we in St. Louis have a tendency to cling like a leech to tradition, or to emulate Walter de la Mare's old Jim Jay who "got stuck fast in yesterday." Whatever the reasons for our present situation something must be done to change the pattern—and quickly. Dr. Herman Biggs, one of New York City's great health commissioners, said many years ago that public health is purchasable, and that statement was never more applicable than in St. Louis today. . . .

Present personnel practices of the Department of Personnel, such as the recruitment and selection of professional and technical personnel, equality and adequacy of pay, and provisions for economic security upon retirement, are not those which fos-

ter adequate public services. This is also a factor in our inability to recruit and hold competent professional personnel.

As was pointed out, the present budget of the health division is grossly inadequate. Preventive medicine pays enormous dividends as compared to the costs of hospitalization.

If we were on top of the job in preventing illness and prolonging life, a very large number of persons who are now in hospitals would not be there. For example, tuberculosis, diabetes, various facets of heart and mental diseases, nutritional disturbances, et cetera, are preventable in varying degrees.

I have always contended that in budgetary matters, as well as in other situations in life, first things come first. Certainly the protection and promotion of the public health by the official agency is tremendously more important than many other activities engaged in by the city government, and yet we find the budget of the health division being included in a 10 percent to 20 percent across-the-board cut when the city is in financial straits, as it is at the present time.

This just doesn't make sense and, in my judgment, shows a lack of intellectual foresight.

Statement¹ of

DR. ELLIS SOX

Director

San Francisco Department of Public Health San Francisco, Calif.

The Department of Public Health in San Francisco administers not only the essential preventive public health services but in addition also provides medical services for the indigent sick, the tuberculars and the mentally ill and custodial services for the aged who are not ill.

The foremost problem facing the people of San Francisco is the provision of services, both medical and custodial, for the aged and the infirm. The primary facility operated by the department is Laguna Honda Home, which has a capacity of 2,070 people. There are 900 hospital beds which were occupied last year to 99.9 percent of capacity. The remaining 1,170 beds are for ambulatory persons, which occupied these facilities to only 90 percent of capacity. During the last 15 years the total capacity has been increased by about 10 percent,

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

but the number of hospital beds has been doubled during the same period.

This indicates to us that as our population gets older, there will be an increased need for hospital care for these same age groups, which will require more and more medical and hospital care as their number increases and their span of life lengthens. Coupled with this will be an increase in the need for community facilities for the care of the aged not in need of bed care, but in need of guidance, recreation, and just ordinary home care.

This problem is not unusual throughout the country, and the President's Commission may have studied this problem and will develop some recommended lines of procedure. It appears to us, however, that the people of San Francisco must sit down together, study the problem as it exists and as it will develop, and come up with the answer for San Francisco. There are many resources available to meet these problems, but they have not been brought together to tackle them jointly.

Care for Aged

There are public and private facilities which exist for hospital and custodial care. If we must enlarge the public hospital facilities, then through organized community effort we must seek means to develop home care for the aged who do not need hospitalization at either public or private institutions. Perhaps this can best be done by studying the possibilities of home care in private—let us call them “foster”—homes, where a single person or a couple could live on their retirement or pension allowance.

There must be a stimulation of our younger and middle-aged to accept not only the financial responsibility for their parents but the affectionate home environment they need. And this same type of home must be provided by others for those without living offspring—just as we do for children. This approach will decrease the emotional catalyst which produces rather rapid physical and emotional deterioration, which so often occurs when an elderly person loses his emotional tie to his family and his old environment.

Such a program is one which must be entered into by the community as a whole—not by just a part of it. There must be made available clinic facilities, perhaps housekeeping services, and a visiting service for shopping, et cetera. It may be necessary to enlarge our existing nursing service.

The point which must be made is that this is not the government's responsibility alone. It is the responsibility of the community at large—its people, its organizations, and its government. . . .

Problem of Emotional Health

A second general problem is one primarily in the field of preventive medicine: this is the problem of emotional health.

The Department of Public Health sees this problem from both the therapeutic and the preventive side. We operate hospital facilities for the mentally ill needing care, not exceeding 90 days. We also operate a clinic which has helped many chronic alcoholics. A good preventive program might decrease the need for these services, and certainly would decrease the other manifestations of emotional illness which this community shows in a number of ways.

A rate for cirrhosis of the liver of almost five times the national rate indicates, in part, an emotionally sick population. This is our fifth cause of death in San Francisco while in the United States it is thirteenth.

The problems the city has in juvenile delinquency, in the number of accidents and incidents of violence associated with alcohol, all point to the need for control of the emotional environment in the same way we have controlled the physical environment. This is not done by enforcement or by government. It is done by proper use of all our resources toward a common end.

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Redevelopment of Blighted Areas

The work of the Department of City Planning and the Redevelopment Agency must be better correlated in the other official agencies, and with community groups in order that redevelopment of our blighted areas may exceed the rate of deterioration. This is a problem which affects the emotional and physical health of all people, and its correction is applied prevention—an economic saving in the long run.

A simultaneous educational program must be carried on in order that the benefits of improved housing may be utilized, and in order that these new facilities will not become the slums of tomorrow. New housing alone will not do the job.

Special Groups

The next three points involve special groups, but will require organized community effort to solve

them. There is not in San Francisco, nor to my knowledge, in the Bay Area, an organized community health program designed to meet the needs of our great industrial population.

The Department of Public Health hopes in the next few years to take its proper place of leadership by establishing a Bureau of Industrial Health to assist industry and other agencies and groups concerned in meeting the problems which affect the physical and emotional health of industrial workers and their families.

A program must be developed which will meet our accident problem. This involves cooperation of all official agencies and all voluntary groups. The Police Department has developed an enviable record in controlling traffic accidents. Much of their program is educational—driving courses, the school traffic project, and the like.

Accidents

Accidents as a cause of death last year were our fourth cause of death—with a rate of 71.6 per 100,000 people—an increase from 1950 of almost 100 deaths. Thirty-eight and four-tenths percent of these occurred in the home. Nationally, only about one-third of accidental deaths occur in the home. So we have a greater problem than the country at large.

Forty-one percent of all accidents happened—if accidents “happen”—to those who were 65 years of age or older; and within these ages, 44 percent of the accidents were home accidents. One-half of the accidents resulting in deaths at 1 to 4 years were at home, and 96 percent of accidental deaths under 1 year were at home. Surely we must work together to reduce home accidents, which maim and incapacitate when they don't kill.

The National Safety Council has estimated that there are 150 incapacitating accidents for every 1 that kills. We had 213 fatal home accidents; we may have had as many as 32,000 home accidents which were not fatal. Deformities and blindness, fractures and other injuries which paralyze and incapacitate, poisoning with permanent injury—these are the things that we are not preventing, because we haven't organized our efforts.

Tuberculosis

The only communicable disease in our first 10 causes of death is tuberculosis. Our rate is decreasing continuously. Our biggest tuberculosis problem is among our oriental population.

Orientals comprise only about 5 percent of our population. Yet they provided us with 15 percent of our deaths from tuberculosis and 11.7 percent of our cases. We must find more cases and find them earlier in order to decrease the spread of the infection and to provide treatment which will decrease the death rate.

Our case-finding among the Negroes must also be increased in order to decrease the spread of the disease in that group.

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Leadership and Organization

We need to decentralize our services through well-planned and operated district health centers under competent district medical officers. Although we can look forward to building health centers assisted by Hill-Burton funds, that time is far off—we are about sixtieth on the priority list for health center construction. Maybe we should build them ourselves.

The best facilities are only monuments unless we have trained administrative personnel and adequately qualified ancillary personnel. The majority of medical personnel in the public health work of this Department are part-time. The average doctor cannot afford to devote his full time to the city's work. We need trained men on a full-time basis just as much as the Police Department, the Fire Department, and the Municipal Railway.

We should be paying salaries adequate to attract trained medical administrators—and until that is done all hope for effectively meeting our official duties must be set aside. With an adequate staff, paid commensurate salaries, the Department can then cooperate in meeting our problems, and at times even lend some leadership.

Statement¹ of

DR. RUSSELL E. TEAGUE

**Secretary of the State Health Office
Harrisburg, Pa.**

The state of health of the citizens of Pennsylvania can be graded as good when compared with other States and with other countries in the world. There have been no serious epidemics in recent years, and with the exception of poliomyelitis and tuberculosis, the communicable dis-

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

ease problems are not great. Infant and maternal mortality rates, as well as all communicable disease rates, are lower than the average for the Nation. Mortality rates of chronic diseases and diseases of late life are increasing, and with the steady aging of the population the problem of prevention of chronic diseases and care of the chronically ill will have to be met.

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The 10½ million people of Pennsylvania are helping to support six large medical schools; almost all hospitals in the State receive State assistance from State tax sources, and there are in operation in the State more nursing schools than in any other State. Medical research within the State is extensive and involves many fields. In general I can state that there is a fairly adequate supply of medical personnel for care of the sick, with the exception that there is a definite shortage of physicians and nurses for tuberculosis and mental institutions. There is also a shortage of facilities—institutions—for the care of the chronically ill.

Public Health Personnel

From the public health and preventive medicine viewpoint, there is a serious and acute problem existing in the shortage of qualified public health personnel of all categories. Public health physicians: If we take the certified men in the United States, we should have 90 men qualified in public health in this Commonwealth. Full-time dentists in the field of public health are very few.

Public health engineers: We could use 100 more in the State at the present time. We need about 25 health educators, 400 public health nurses, another 20 public health nutritionists, a large number of social workers which I will not attempt to estimate, probably 100 trained sanitary and other administrators. They are in extremely short supply, and the only way to be found is to train them, pay for their training or try to entice them from some other State to come and work here.

Although there is a graduate school of public health in the State, it is new and provisions for definite, comprehensive training programs for public health workers in Pennsylvania have not been made nor have funds been provided from public sources to any adequate degree for training of public health personnel—although programs have been started. This latter need is a “must” if we may ever expect to have adequate public health

personnel, and it must come before we can ever have good health departments.

Very few public health personnel ever pay for their graduate education in the field. A man entering public service—his training is usually paid for by some philanthropic foundation or by government, usually local or State.

Lack of local health departments is a second important need in Pennsylvania. There are only two large full-time health departments in the State serving the city of Philadelphia and the city of Pittsburgh, which comprises about 21½ million population. These are fairly adequately staffed, and many other small municipalities have part-time or only partial health services. The State health department serves all the other communities in the State with public health facilities.

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County Health Departments

Next to public health personnel, the greatest need is the establishment of about 40 adequately staffed county, or joint county health departments, in the State of Pennsylvania to give complete coverage to the rural areas. A new State law passed last year permits the establishment of these county health departments. They should be adequately financed from funds supplied locally and through the State.

Specific health problems that exist throughout the Nation are under study and some may be met.

For example, I should like to call your attention to one that occurred just this month. About 16,000 migrant workers were imported into the Commonwealth to work on the farms digging potatoes and picking beans. Without warning we were notified that they were there. The sanitary supervision did not exist. The medical profession in the area were taxed and there were insufficient health personnel to give them even a semblance of health supervision. The impact upon the community in which these 16,000 workers hit was sudden, abrupt, and caused a serious health hazard. Now, if that community had had a properly staffed local health department the local medical society and local hospitals could have met the need in a routine manner.

Area of Greatest Need

In our effort to make this presentation brief I am going to re-emphasize the three points that I have made and leave other details for other

members who will be heard. The greatest need for public health in Pennsylvania are:

(1) The shortage of public health personnel properly trained and qualified to staff department of health; and

(2) Lack of local health departments with adequate staff and financial support; and

(3) Institutional facilities for the chronically ill.

Adequacy of Interns

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Commissioner ALBERT J. HAYES. Doctor, do you care to give the Commission your opinion with reference to the question of the adequacy of interns in Pennsylvania hospitals?

Dr. TEAGUE. From the six large medical schools in the State we turn out a great supply of interns. Interns like to select hospitals to get their service near centers of education and teaching hospitals. They get better training. So naturally the interns migrate or go to the large centers for their training, leaving rural hospitals without interns in many instances or with only a few. It is not so much the inadequacy of the local hospitals to teach the intern. It is that they like to get near centers of education in Philadelphia and Pittsburgh where they migrate to. I do not say that we have a shortage of interns, however, because I believe they are concentrated in these cities near educational centers.

Commissioner HAYES. That, of course, is a problem of distribution again, is it not?

Dr. TEAGUE. Yes.

Commissioner HAYES. Do you have any views as to how this problem might be solved?

Dr. TEAGUE. No, I have not; not at the present time.

Commissioner HAYES. It is a difficult problem.

Physician Distribution

Dr. TEAGUE. You mentioned the problem of distribution of physicians. I touched upon it slightly. I think that we have enough doctors in Pennsylvania and my impression from traveling all over the State is that they are fairly adequately distributed. We have very few discrepancies in distribution of physicians in Pennsylvania.

When we find an area that is not covered by a physician it is an extreme exception. Only in very remote rural areas that are not economically sound and cannot support a physician—sparsely settled—do we have a shortage of physicians. To-

day, with good roads there is no area in the State that is not close to cities or towns that have—we have 47 third-class cities in the State and none of them is removed from any rural area so that the area cannot be reached within a very short period of time.

I do not feel that our distribution problem for practicing physicians is a real one in the Commonwealth.

Statement¹ of

MR. E. W. STEEL

Professor of Sanitary Engineering

The University of Texas

Austin, Tex.

The present situation is particularly difficult for the public health administrator insofar as personnel is concerned. The increasing complexity of health services requires a continually higher level of technical or scientific training. At the same time, there is both a shortage of trained workers and increased demand for them. This increased demand results from the expansion of health work into such fields as mental hygiene, geriatrics, industrial hygiene, and dental hygiene, all of which are expected in the health protection services of a modern community.

Also increasing is the diversion of personnel into research in preventive medicine. Finally, there has been a notable loss of our most highly expert workers into the foreign field, as part of our Federal Government's plan to aid countries less fortunate than our own.

The acute shortage of workers in practically all public health specialties may be met with indifference, or it may be viewed as a challenge to the abilities and awareness of legislators, health administrators and educators. It is especially gratifying to the speaker, as a public health educator, that the Commission on Health Needs of the Nation is exploring health education, since there is a correlation between it and the existence of personnel shortages.

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In order to meet needs of health departments, schools of public health have been established at a few universities. The latest list of such schools accredited by the American Public Health Asso-

¹ Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

ciation shows 11, of which only one can be at all considered as in the Southwest. This is at Tulane University in New Orleans. . . .

No Accredited School of Public Health

In the Southwest, which is vast in area and progressing rapidly in industrial development and with the fastest growing cities in the Nation, there is no accredited school of public health, and one newcomer in the field. Also, there is only one school in Texas that gives graduate work in public health nursing. In sanitary public health engineering we are somewhat more fortunate. Several engineering schools in the Southwest offer adequate training in this field.

I make this point as to scarcity of public health training in this area because, in my opinion, public health problems are to a considerable extent variable with respect to regions. The attitudes and social characteristics of populations differ and also the environmental factors and the industries. Public health instructions should, therefore, be

aimed at regional requirements, and this calls for adequate regional coverage by schools of public health.

Establishment of More Schools

The output of professionally trained workers from the existing schools of public health does not meet the demand. There is, of course, the probability that schools better located strategically will attract more students, because of the greater availability of instruction and the stimulating effect of the mere existence of facilities.

The establishment of more schools of public health, however, would not automatically solve the problem of getting more and better public health specialists. This is partly because instruction in such schools is principally on the graduate level and comparatively few students who have received undergraduate degrees are willing to study for another year unless they can very plainly see commensurate rewards. At present, such rewards are not very apparent.

HEALTH COUNCILS: COMMUNITY REPRESENTATION

Statement¹ of

MRS. NORMA SILVER

Health Council

Detroit, Mich.

The content of this report represents largely the thinking of the member agencies of the Health Council. Following are some of the major health problems as seen by our Executive Committee and member agencies:

1. Current Shortages in Health Personnel

There is a shortage in Metropolitan Detroit of prepared public health nurses, graduate nurses and practical nurses. A conservative estimate made in December 1951, indicates that Greater Detroit is now 15 percent short of the number of professional registered nurses required to maintain health services in hospitals and public health agencies. Within the next 5 years 1,900 more beds will be open to Detroit area citizens as a result of our private hospital building program.

At the present rate of supply of professional nurses, we will find our area 25 percent short in meeting those needs. There will be approximately

3,500 additional governmental (municipal and State) hospital beds to be added to present facilities in the area for care of tuberculosis, mental and nervous patients which could bring our professional nurse supply, 5 years from now, to a critical shortage considerably over 25 percent.

We are in the midst of lean years of recruitment for professional nursing schools, as depression babies reach high school graduation. The birth rate in Detroit dropped to its lowest in 1933 and did not return to predepression levels until 1941.

Therefore the number of candidates for nursing schools are presently at a low ebb and recruitment is further disadvantaged by the more attractive earning possibilities in other fields that may be realized without as great an investment of time and money.

Advances in medical science have made new service demands on professional nurses. It is imperative that girls entering professional nursing be well qualified and well prepared to perform highly technical scientific and managerial duties of nursing care. We have reached the point in the field of nursing where we know that shortages are not only due to decreased numbers of nurses but to increased demands for their services. It has become vitally necessary to devise ways of using our

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

professional nursing skills and experience with the greatest possible economy and of using auxiliary personnel intelligently so as to give safe nursing care to all who need it.

Educational standards cannot be lowered, but nursing education can be brought within the reach of every properly qualified candidate through scholarships or similar aids.

Practical nurse training facilities need to be increased in the Detroit area, and emphasis must be placed here in recruiting the large numbers which can be made available for future bedside care. The cost of this training program must likewise be kept within reach of the women who can be recruited. Some attention, also, needs to be given to the training of nurse educators, supervisors and administrators and appropriate compensations and scholarships in this area are extremely important considerations.

There is also a shortage of dentists, physical therapists, dental hygienists, health educators, and, in fact all types of workers in the health field in this area. It has been suggested that more effort be made to recruit male personnel into these fields as well as in the nursing field. We are also experiencing a severe shortage of psychiatrists in this area.

II. Adequacy of Local Health Units

We are fortunate in the Greater Detroit area in having excellent local health departments. However, some of these departments are disadvantaged by professional staff shortages and by budget limitations and cannot do as efficient a job in certain areas as the quality of the administrative and professional personnel they do have would permit.

More efficient operation on the local level could be obtained if funds allocated by the Federal Government through the State health department to local health departments were not earmarked. The local health officer would then be in a position to spend these funds as local needs indicated.

Further, the amount of money allocated by the State health department to local health units should be based on program needs, the adequacy of program to meet the needs and incidence of disease rather than strictly on financial need.

Some consideration needs to be given to the percent of this Federal money that is kept by the State health department and the percent that is allocated to the local health units that are giving direct service.

Consideration should also be given to question of how Federal money allocated to States should be used. Should finances required for the maintenance and operation of State health departments be the complete responsibility of the State, thus leaving all Federal funds for the extension of local health services, where they are most needed? Approximately 40 percent of the population of Michigan lives in Wayne County. The Wayne County death rate from tuberculosis represents 61 percent of the total State death rate from this disease. These figures are evidence that our local health services need to be given a financial opportunity to be extended in terms of the population they serve.

III. The Adequacy of Medical Research

We are aware that a great deal is being done by the Federal Government and private philanthropy in this area, and yet we do not have answers to many of the important questions involving control of diseases. Some consideration needs to be given to the relative amounts of research being done in different diseases. In some cases a great deal of research is being supported to the advantage of certain diseases. On the other hand there are diseases of importance in terms of incidence, which do not have the emotional appeal to voluntary contributors, and are not receiving adequate funds for effective research.

IV. Degree to Which Hospitals and Clinics Meet Existing Needs

The Detroit metropolitan area is currently well supplied with general hospitals, but we lack facilities for the care of tuberculosis, mental disease, chronic illness and the physically handicapped. Our out-patient clinics facilities are too centralized for the convenience of people—particularly mothers with young children and those requiring pre-natal care. We are in great need of additional psychiatric clinic services for both adults and children.

We need additional hospital facilities for the chronically ill as well as other types of facilities and services for the semiambulatory aged. We are presently trying to establish a comprehensive rehabilitation center for the physically handicapped which will include not only the services of physical medicine, but also opportunities for social and vocational adjustment. A true comprehensive rehabilitation center is costly to operate; the cost per case is extremely high when compar-

ing the same period of time to bed care. The economic saving to the community and the Nation results, however, when the individual has been physically, socially and economically adjusted to his maximum and he is no longer a public charge.

V. The Extent to Which People Are Able To Afford Adequate Medical Care

Some consideration needs to be given to the provision of medical and hospital care to retired workers who are living on pensions which represent greatly reduced income.

VI. The Adequacy of Federal, State, and Local Health Programs, With Emphasis Upon the Desirable Level of Such Expenditures

In our opinion it is the local health programs that need strengthening, rather than the Federal and State programs.

A total health education program is needed in order to publicize available services and to increase the demand for these services. There is a great deal of difference between the need for health services and the demand for these services.

A health education program must stress the area of prevention of disease and waken a feeling of responsibility particularly on the part of parents of young children for the early correcting of remedial defects.

Statement ¹ of
MISS FRIEDA BRACKEBUSH
Health and Hospital Division
Social Planning Council
St. Louis, Mo.

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The Health and Hospital Division includes in its membership 77 agencies, institutions and organizations. . . . Through committees and other working groups, the members of the health and hospital division have devoted a great deal of time and effort to the study of health and medical care problems confronting this community. . . . It has not been possible to attack all of the problems and, in some areas, although a considerable amount of effort has been expended, progress has been very slow. . . .

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¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

Local Health Unit

For a number of years, the health and hospital division has become increasingly concerned about the inadequacies in the services being provided by both the city and county health departments. Special committees are currently trying to find ways and means of strengthening existing public health services, as well as ways to develop new services for which the need is evident.

The city of St. Louis, with a population of 856,796, according to the 1950 census, maintains a city division of health, which provides public health services for this area. Maternal and child health services and medical services necessary to the control of communicable diseases, particularly tuberculosis, are inadequate to meet the need, due to a large extent to lack of medical personnel, particularly in administrative and supervisory positions.

It has been impossible to attract qualified physicians to fill these positions because of relatively low salaries. After continued effort to recruit individuals for these positions, it now seems evident that it will be impossible to fill them unless higher salaries can be offered. On the other hand, adequate services cannot be provided until competent supervisory personnel is available to assume responsibility for the development and direction of those services.

Serious Financial Problem

One of the important factors contributing to the personnel problem confronting the city health division is the serious financial problem confronting the city of St. Louis. . . . Funds are not available for the development of new services under the auspices of the health division, nor for sizable adjustments in the salaries of personnel in administrative and supervisory positions.

A special citizens' committee recently appointed by the mayor is currently attempting to find a solution to the city's financial difficulties.

St. Louis County, with a population of more than 406,000, according to the 1950 census, depends for its public health services upon the St. Louis County Health Department, and limited health services provided by some of the larger municipalities. St. Louis County includes in its boundaries more than 90 incorporated municipalities, ranging in size from less than 100 population to one city of more than 39,000.

Some of the larger cities provide limited public health services for their residents, but in no community in St. Louis County are adequate public health services available.

The St. Louis County Health Department is operating on funds made available by a special tax for public health purposes of four cents per \$100 valuation. The amount available for public health services provided by the County Health Department from this source is equivalent to about 75 cents per capita, which is only one-half of the minimum of \$1.50 per capita recommended for the operation of a local health department. It has been estimated that additional expenditures by municipalities for public health services may be equivalent to an additional 5 cents per capita.

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County Health Department

As in the city, the county health department is confronted with a shortage of personnel in professional and technical positions . . . due to the fact that the demand for personnel in most of these positions far exceeds the supply available in this community and in the country as a whole. It, therefore, becomes extremely difficult to fill positions unless salaries comparable to those being offered by industry and other positions of similar responsibility can be paid.

Due to the factors mentioned above, medical, dental, and nursing services available through the St. Louis County Health Department are grossly inadequate. It has been impossible to develop any services in the field of chronic and long-term illness.

Control of Tuberculosis

Problems confronting the St. Louis community in both the City of St. Louis and St. Louis County in the control of tuberculosis clearly indicates a need for more adequate public health services. The death rate from tuberculosis in the City of St. Louis was 33.6 per 100,000 in 1951, with a death rate of 10.6 per 100,000 in St. Louis County. A total of 124 cases in both city and county were not reported until after death. This indicates the need for a more vigorous case finding program. Furthermore, only 11.9 percent of the new cases reported during the year were in the minimal stage as compared with 23.7 percent for the country as a whole in 1950. A continuous waiting list for hospitalization of cases discovered in both the city of St. Louis and St. Louis County com-

plicates the problem and indicates a lack of adequate resources for the control of this disease.

Another important complicating factor in the control of tuberculosis is the inadequacy of public assistance grants in the State of Missouri. Because of limited appropriations, families dependent upon public assistance frequently receive grants which represent only a portion of the minimum budgetary needs of the family. Adequate care for the patient and other members of the family in the patient's home is almost impossible under these circumstances.

Chronic Disability

Another problem of increasing concern is that of providing more adequate services for those suffering from chronic disability and long term illness. The increase in the incidents of cancer and heart disease resulting in the partial or total disability of an increasing number of persons, as well as the increase in the number of the persons in the population who are suffering from the infirmities of old age, has resulted in a need for additional resources for custodial and nursing care, as well as medical supervision.

The City of St. Louis maintains a large institution for the infirm and chronic invalids in addition to two large general hospitals. The infirmary and the chronic disease hospital are crowded, and several hundred people are waiting admission. Many of these are being kept in the general hospitals until their transfer can be arranged.

St. Louis County, on the other hand, has no public institution for the care of chronic invalids and the infirm, other than its general hospital. At the present time, St. Louis County is dependent upon commercial nursing homes for custodial and nursing care for persons who no longer need the facilities of the general hospital.

Negroes Refused

There is, at the present time, no commercial nursing home which will admit Negro patients. As a result the only resource available outside of the general hospital for the care for Negroes in St. Louis County is the patient's own home, or the home of relatives or friends. With no provision for home medical care in St. Louis County for those who are unable to pay for the services of a private physician, care for many chronic invalids is quite inadequate.

Because of the limited resources available, very little consideration can be given to the particular

type of care which an individual needs. As a result, chronic invalids who need a great deal of nursing care are frequently housed in the same room with individuals who need only good custodial care.

Both the City of St. Louis and St. Louis County are confronted with serious problems in planning for more adequate care for chronic invalids and the infirm. The City of St. Louis is giving serious consideration to ways and means of establishing another institution to provide care for these individuals. A serious complicating factor is the city's financial condition, which has made it extremely difficult to make sufficient funds available for the continued operation of the existing institutions.

St. Louis County, which has no institution other than the general hospital, is confronted with a question with regard to the kinds of facilities needed, and the extent to which beds should be provided in a public institution. These matters are currently receiving serious consideration by committees of citizens who are vitally concerned about these problems.

Lack of Medical-Nursing Care

Another important factor which complicates the problem of care for chronic invalids and the infirm in this community is the lack of provision by the State for medical and nursing care for recipients of public assistance. . . . A large proportion of the chronically ill and infirm, who are unable to provide care for themselves, are receiving public assistance grants.

Extension of the public-assistance program to provide for the purchase of medical and nursing care by the State of Missouri for those individuals now receiving public assistance would ease the financial problem for local communities, particularly urban areas.

If medical supervision and some nursing care could be made available to recipients of public assistance in their own homes, or in the homes of relatives or friends, it would make it possible for a number to remain in the community rather than being institutionalized.

Without provision for purchase of medical and nursing care, many recipients of public assistance now in commercial nursing homes in this community are receiving inadequate care. Without medical supervision and nursing care, very little progress is being made toward the reduction of disability and the restoration of these individuals to

"the fullest physical, mental, social, vocational and economic usefulness of which they are capable."

The Mentally Ill

This community is also confronted with serious problems in providing care and treatment for the mentally ill. The past few years have witnessed some expansion in out-patient services, but facilities for early hospitalization of those for whom hospitalization is recommended is very inadequate.

The City of St. Louis maintains a large division for the observation and early treatment of the mentally ill. That division is overcrowded because State mental hospitals, to which many of the patients are referred for further treatment, are overcrowded and unable to accept cases. At the present time, the observation division can admit only those cases which are considered urgent.

A limited number of voluntary general hospitals in this community have psychiatric divisions for observation and early treatment. The cost of care in voluntary hospitals is too expensive for many of the individuals needing this service and they, therefore, are unable to use the facilities. Voluntary hospitals are also confronted with a problem in arranging for the transfer of cases to State mental hospitals for further treatment, when that is recommended.

St. Louis County has no beds available for psychiatric cases needing observation and treatment. Through an agreement with the City of St. Louis, the county has had access to some of the beds in the city observation division. With the crowded condition in the city, facilities available to St. Louis County have become extremely limited. Serious consideration is now being given to possible solutions to the problem confronting St. Louis County. The possibility of providing care for some of these individuals in their own homes, or in the homes of relatives or friends, has been recognized, but the development of such programs presents serious difficulties because of the shortage of professional personnel to provide the supervision needed.

It is most appropriate that we acknowledge with real appreciation the availability of Federal funds for research, training, and prevention in the field of mental illness. Funds from this source have assisted greatly in the initiation of a program of prevention through small child guidance clinics under public auspices in both the City of St. Louis and St. Louis County. Funds available for training through St. Louis University and Washington

University have provided for this community a limited number of psychiatrists, psychiatric social workers, and psychologists, which are so essential in a well-rounded mental health program.

Development Programs Needed

It is evident that the solution of the financial problem confronting this community would be a significant step toward the development of more adequate health services.

On the other hand, it must be recognized that if sufficient funds were made available to this community overnight, it would not be possible to employ the professional and technical personnel needed to develop the various services in the field of health and medical care, because the demand for trained personnel in this field far exceeds the supply.

This fact emphasizes the need for development programs which are directed toward the recruitment of young people for professional and technical positions in this field and, perhaps, providing assistance through scholarships and other means to enable them to complete the necessary training.

Consideration must also be given to ways and means of providing sufficient educational and training facilities, should the happy day come when an increasing number of persons are attracted to positions in this field.

Statement¹ of

DR. ELLEN WINSTON

Commissioner of Public Welfare

Raleigh, North Carolina

Since the indigent (namely persons who require financial aid to meet all needs) and the medically indigent (namely persons who require financial aid only to meet the costs of illness) are readily identifiable groups, they also should be groups for whom necessary programs for providing medical aid can be promptly developed if we are willing to finance such programs. There is ample evidence that neither private charity nor acceptance by hospitals of free patients can provide the answer. . . . While an extension of group insurance downward into a larger portion of the medically indigent is certainly feasible and desirable, . . . the basic problem of providing adequate medical care and hospitalization for the

lowest income groups is now generally recognized as a governmental responsibility.

The Poor Get Less

Experience in North Carolina in this area can readily be related to other southern States. . . . In general we know that poverty and above average morbidity rates go hand in hand—that poor people are less likely to receive needed medical care, that often such care is so long delayed that the chances of recovery are reduced, that the indigent patient remains in a hospital an average of 9.9 days in this State, as compared with 5.9 days for paying patients, due primarily to the chronically ill among the indigent, and that the entire situation is aggravated by the nutritional deficiencies and inadequate housing and home care of sick people who are also poverty stricken.

With reference to a study of aid to dependent children and their nutritional needs, we actually found that 98 out of every 100 of those persons did not meet a minimum standard because of lack of funds. And as of October of this year, we will be paying 70 percent of the minimum needs for the approximately 50,000 children under that program.

Because of the large numbers of people involved, and the amount of public funds required to provide needed medical care, it is essential that there be objective determination of need for care through governmental appropriations upon an equitable basis throughout a given State. This can be done most effectively by welfare departments using a State-established standard for certification of indigency. Such a procedure protects: (1) Needy individuals in guaranteeing like treatment of persons in like circumstances; (2) the public, since funds are spent only for clearly demonstrated need; and (3) the vendors of medical care, who know the objective basis upon which the need for "free care" is determined.

Hospital Certification

In North Carolina there are actually several State-wide plans used for certification for hospitalization. The most rigorous scale is used for the indigent whose medical needs are met, if at all, primarily from county appropriations. A somewhat less rigorous scale is of practical necessity applied to determine the medically indigent and to use most effectively and economically funds available for medical care and hospitalization from State or Federal appropriations.

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

An important point to bear in mind with respect to meeting the medical care needs of the clients of welfare departments is the fact that administrative costs are already largely taken care of. The cases are generally known to the departments and to a large extent certifications can be made on the basis of previously established need. In other words, funds for medical care of the indigent can be handled through welfare departments at less administrative cost than under any other method so far suggested. . . .

Funds Appropriated

State and local governments have appropriated increased funds for medical care and hospitalization of the indigent and medically indigent but few units of government have been able—or at least considered themselves able—in this section of the country to provide adequate funds. During the 10-year period, 1941–42 to 1951–52, the 100 counties of North Carolina increased their obligations for this purpose through appropriations to local welfare departments by slightly more than 300 percent. During the decade, however, cases benefiting increased only 80 percent, while the average expenditure per case increased approximately 145 percent.

This greater effort by local governments has only ameliorated without solving the situation. Moreover, a recent study of charges to county welfare departments in North Carolina by hospitals indicates wide variation in costs for indigent patients for the same service in hospitals of comparable size. For example, in hospitals of 100 to 199 beds, the charge for a basal metabolism test varied from \$3 to \$10.

* * * *

Recommendations

In the light of our present knowledge of the needs and of the resources, the following recommendations are proposed, with special reference to low income, predominantly rural States:

1. That within a given State all hospitalization and medical care for indigents be certified by public welfare departments on an equitable budgetary basis, taking into account both costs of care and any available resources of the patient.

2. That laws restricting the eligibility of an individual to receive needed medical care from public funds be abolished. In other words, if you are sick and you have no money, you need help where you are.

3. That all public funds for medical care of the indigent be obligated on a per patient basis rather than in a lump sum to the vendor. This is essential to determine actual services rendered for a given appropriation; in other words, how many cases you can actually care for with a given amount of money.

4. That there be an active program to develop out-patient clinics at hospitals through the State to meet the varied medical care needs of the indigent and medically indigent, expanding upon the many excellent specialized clinics now in operation in both rural and urban areas.

5. That steps be taken to utilize the most economical method for providing needed drugs to indigent cases. This is an area that is very costly and upon which has been done very little actual work.

6. That actual cost be paid for hospitalization of indigent patients; such costs, however, to be limited to actual patient care and not to include per capita costs for special programs of hospitals.

Now, we in public welfare believe that hospitals should be paid what it costs them actually to take care of a patient. We have not done that in the past in many, many instances.

7. That sufficient funds be made available in low income States to take advantage of Federal participation in payment to vendors for medical care of public assistance recipients. The States are already using Federal funds in making subsistence payments to such cases so that no new policies are required. Because of administrative regulations, a pooled fund appears to be the more feasible plan for utilizing available Federal aid under a plan of medical care and/or hospitalization which will be State administered or locally administered and State supervised.

In North Carolina such a plan is under consideration. If sufficient State matching funds are made available, the problem of hospitalization costs for some 150,000 recipients of public assistance will be essentially solved. In other words, we believe that through this plan we can at least take care of the lowest income group of all.

8. That any long-range program for State participation in the costs of medical care for indigents take into account the varying financial ability of counties through some type of equalization fund.

9. That there be increased attention to the use of alternative and less expensive types of care for low income persons who do not require continued

hospitalization, that is, (a) convalescent homes for persons who continue to require individualized patient care and (b) custodial or sheltered care in licensed homes for persons who simply require a substitute for home care. This latter type of care has been proved to be a definite resource for senile cases formerly in State hospitals as well as for mentally normal aged and infirm individuals.

10. That there be increased attention to both homemaker services and home nursing services through public and voluntary welfare and health agencies so that when practical, persons may be cared for in their own homes.

It is believed that implementation of these recommendations will mean earlier care and hence shorter, less expensive illnesses for indigent people, more nearly meet the financial problem hospitals face in caring for indigent patients, and help paying patients by reducing the drain on hospitals for free or partly free care. Most important, to the extent that illness is prevented or given early treatment, costs of indigent care should be reduced over a long-time period and the human resources of the State will be increased as persons are restored to effective, productive living.

Statement ¹ of

DR. J. L. T. APPLETON

Chairman

Health Division of the Advisory Committee

Health and Welfare Council

Philadelphia, Pa.

The Health and Welfare Council of Philadelphia represents many of the health and welfare interests of a three-county area with a population of approximately three million people. The counties included in this area are Philadelphia, Montgomery, and Delaware.

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As in any community of this size there are deficiencies in health services from the viewpoint of those professional and lay people who are looking forward to an improved program. There is never satisfaction with the status quo and, therefore, we believe this report should be considered as one which expresses needs in the development of a forward-looking program. Many positive

and progressive steps have been taken for health services in this area, but we present the following needs in light of further development of good health.

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Segments of the public health problem as observed in the activities of the Health and Welfare Council:

Personnel

(a) A shortage of trained personnel: This shortage is caused by a general lack of personnel in certain health disciplines, and the failure to provide the positions in this geographic area to well-trained and qualified personnel. Following are some of the personnel not available:

1. Nursing personnel: Nurses in the Philadelphia area are in short supply for general and special institutions and for official and voluntary public health nursing organizations. . . . The Nursing Council has an intensive program for nurse recruitment, but we are still faced with a short supply of nurses. We have no figure available on the shortage of nurses in institutions . . . but in the public health nursing agencies we have faced a constant and increasing shortage of nurses over a 3-year period. One of the largest voluntary nursing organizations has been operating 15 percent below the number of budgeted positions during the past year, and the official public health nursing service has not been fully staffed.

2. The shortage of child psychiatrists presents a constantly pressing problem. If all the funds necessary for children's services were available, personnel in this field could not be secured. Leaders in this field have expressed this need many times.

3. Public health educators are in very short supply. This may be caused by our failure to recognize the need for this type of personnel. There are no more than five well trained public health educators available to 3 million people in all of our official and voluntary health services. This causes an extreme hardship in the public health program since it is based on education of the citizen for the promotion of health and prevention of disease.

4. Other trained personnel in short supply are social workers, sanitary engineers and inspectors, and trained public health physicians. These shortages are caused as much by failure of Pennsylvania generally to have a modern public health pro-

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

gram as it is by the shortage of personnel in particular fields. We have no means of measuring these shortages.

Dental Service

(b) A general lack of dental services accentuated by failure to use fluorides. . . . I am happy to bring that to your attention. Of the approximately 35 different water supplies in the 3-county area none use sodium fluoride for prevention of dental caries. This creates a greater problem for the less than adequate dental clinic services available. In the 1949 Philadelphia public health survey it was indicated 166,000 children in Philadelphia alone were not receiving adequate care. These services are constantly demanding more clinic service in certain areas of the city. The need is far from being met in Philadelphia. A similar condition exists in Delaware and Montgomery Counties where many geographic areas are completely uncovered with such services and other higher populated areas have clinic services available on one-half or one-day per week basis. School personnel here, too, are constantly asking for more service.

Public Health Education

(c) The public health education program is extremely limited because of the lack of personnel as mentioned above. . . . It must be pointed out that few of the educators have any formal training for their positions. The public health program of this area could be greatly improved by having a greater number of well-trained public health educators.

Psychiatric Services

(d) The psychiatric services are inadequate in the tri-county area. In the official program of Philadelphia there is no division or department set up to work in the field of mental health. Bed facilities and out-patient services cannot nearly meet the need in the Philadelphia area. The Health and Welfare Council is pressed continuously with the need for beds and the need for clinic services for both adults and children. The children's clinic services which are available in Montgomery and Delaware Counties are poorly coordinated and inadequate to meet the need. In Philadelphia, children's clinics need to be expanded and other services need to be developed. . . .

Rehabilitation

(e) Rehabilitation Program: In June 1950, a study was conducted by the Health and Welfare Council, "A Community Plan for Rehabilitation," which clearly indicates that the existing facilities for physical and vocational rehabilitation are inadequate in the tri-county area of Delaware, Montgomery, and Philadelphia Counties. In this study, need is shown for a comprehensive rehabilitation center where disabled persons would be screened to determine their treatment and training potentialities and provided with physical and vocational rehabilitation. . . . Coordinated with this should be homebound employment, sheltered workshop facilities, and aggressive industrial placement service. . . .

Chronic Illness

(f) Chronic illness has received limited attention in the Philadelphia area. There has been a number of abortive attempts to start work on this problem, but from a wide community viewpoint very little has been done. . . . the community resources are extremely limited when faced by a problem of great magnitude. . . . The development of a city-wide home care plan could be very effective for this type patient and conservative of community resources. From the viewpoint of the Health and Welfare Council, this is probably one of our greatest problems.

Tuberculosis Facilities

(g) Tuberculosis facilities are still inadequate. . . . With available facilities as a possibility in the near future, a screening program might be instituted so that treatment for early cases would be provided. It must be recognized in Pennsylvania that we have had empty beds in our State institutions, and the shortage of nurses referred to in Paragraph A-1, contributes to the problem in the tuberculosis field.

Health Services Growing

. . . The problems which we present are ones which come to the Advisory Committee generally from the community at large. As a need is felt in the field of mental health or rehabilitation, pressure is exerted on the Health and Welfare Council to organize the community to meet this need. We are expressing a feeling of the community in this way.

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When an organization is asked to express the needs of a community, it is realized that the answer to that question appears rather negative. We want in no way to leave the impression with the Commission that there have not been many positive factors in the development of health services in this area. Official and voluntary services work well together to solve problems.

Commissioner ALBERT J. HAYES. Dr. Appleton, will you answer one question if you can, please?

Dr. APPLETON. I hope that I can.

Commissioner HAYES. Would you care to express an opinion as to the adequacy of general practitioners in this general area?

Dr. APPLETON. I am speaking purely as an individual. My impression is that it is very high caliber. The quality of service is very high. I believe that quantitatively the supply is better than in many communities with which you have had dealings in the past. However, I believe that there is a representative of the Philadelphia County Medical Society present who can speak with much greater authority than I can on this point.

Statement¹ of GEORGE FORTUNE

Director

Cleveland Hearing and Speech Center Cleveland, Ohio

On the basis of community plans, about 5 years ago the Cleveland Hearing and Speech Center was developed with the direct idea of meeting some of the needs in which the Commission is interested. After planning on the part of the Health Council and the Welfare Federation, Western Reserve and interested groups of lay leaders and professional leaders from other agencies, this Center was established in 1945. In the past 7 years there has been a phenomenal growth in the provision of services for those handicapped in hearing and speech in this community.

Our particular agency also serves outside of the community, doing some work throughout the greater Ohio area. In fact, we are serving as the specific agency for the handling of veterans' speech and hearing problems in the entire northeastern Ohio area.

Incidence of Handicapped

Thinking in terms of the incidence of speech and hearing problems, which unfortunately our figures on the handicapped do not show and therefore get too little attention, there are approximately 3 to 5 percent of the population with hearing problems and about 3 to 5 percent of the population with speech problems which need actual attention.

We feel we are only beginning to scratch the surface of these particular disabilities or rehabilitation problems, but we do feel that the outlook is good and that the continuing slow progress toward meeting the needs is going on in this community and throughout the State. We find that here in Cleveland last year we saw approximately 1,992 cases at the Hearing and Speech Center for rehabilitation, and at the same time we saw approximately 19,370 people who received some service from the Center in terms of recreational rehabilitation, training of qualified personnel, research, and public education.

On the other hand, although the situation is excellent in Cleveland at the present time, we have recently surveyed Cuyahoga County to get the picture outside of Cleveland, and found it higher than the national incidence of hearing problems, 5.7, and higher than the national incidence of speech problems, 11.6. We also found that not a single service in speech and hearing therapy is being provided.

So that you have in your metropolitan area perhaps an excellent program, while just outside Cleveland you may not have a good program at all. In Cleveland, hearing and speech services are vested in the community agency, which is a dual program in its connection with Western Reserve University for training and for service on a community level. In addition you have a program within the public schools, which also has seen phenomenal growth within the past 7-year period, partially because of the community planning and the establishment of the center.

In 1945 there were only four speech and hearing therapists working in all of Cuyahoga County and today there are 30, and these 30 have been made possible because of the dual program; we have trained over three-fourths of the people who are working in these schools districts.

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We do not feel as yet that we are handling the problem in Cleveland, but we feel that with the

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

planning that has taken place and the growth in the past 7-year period, that we have good reason to believe that it will be handled in the not too distant future.

Personnel Problem

Pointing to the problem in which the Commission is interested, I believe that we should point out the severe shortage of personnel in fields of speech and hearing. We do not have adequate personnel at the moment to handle the problems for which the facilities were set up. In fact, the new \$400,000 structure which has just been raised by the Cleveland Hearing and Speech Center will have to be staffed with such personnel as we can get, and we feel our big problem will be in securing adequate personnel.

Perhaps some State planning, some Federal planning, some local planning will have to be done in order to aid in the problem of recruitment, particularly in the area of teachers of the staff. In all of the phases of special fields you will find a severe dearth of personnel who are qualified to work with handicapped children.

We feel very strongly that the finding program in this community and in the State is not yet what it should be. We believe that if we could get to these handicapped speech and hearing youngsters very early—for example, the deaf child at 16 months—we could do better jobs in terms of better qualifying these children to fit into a normal hearing and speaking world.

We do not believe that it is necessary for these deaf children to use sign language as a means of communication, because it is a social and vocational hazard. We feel that they should be trained in the use of the English language orally so they can by all means fit better into an integrated society. We think many children who should have lip reading attention are not getting it. We feel that all of these things are allied with the need for research.

Preventive Job Needed

As you may know, in the field of the blind, the deaf and hard-of-hearing, a great deal of money has been spent in rehabilitation, but too few funds have been put forth to do the preventive job of finding the cause of hearing and speech problems and of blindness, so that of course we cannot do as much as we should on a preventive level.

In short, I would say we are progressing here in Cleveland very rapidly with the vast spread of

services for each of the speech and hearing therapies that go through the community health agencies, the public school and through the hospital facilities. We still have a real need for a finding program that is improved, a real need for earlier work with handicapped children who have speech and hearing difficulties, whose problems require research funds, so that we can look into the causes and thus further supplement and aid in the more or less diagnostic program.

We believe that there should be state-wide planning in terms of services and real coordination on the training level so that perhaps the better institution which is training teachers for the deaf can coordinate its work and its philosophy more closely with the universities which are training people in the same field.

But these, I believe, are the essential problems—manpower, need for more research, and the spread of facilities to more children and more effective finding programs which must be done by ancillary personnel as well as by medical odontological screening and so forth.

Public Health Service Funds

Commissioner ELIZABETH S. MAGEE. Mr. Fortune, are there any research funds available from the U. S. Public Health Service?

Mr. FORTUNE. Just recently there have been some funds. The new Public Health Institute on Neurological Diseases and the Blind may perhaps make some funds available for research.

We believe, however, that these funds, instead of going to a few specific centers throughout the country, should be made available to centers in various geographic locations so that all of us may have an opportunity to develop research.

Commissioner RUSSEL V. LEE. Who should do this? You realize that you are way ahead of the country generally in your program here. Is yours supported by Community Chest?

Fund Sources

Mr. FORTUNE. One-third of the funds come from Community Chest; one-third from fees and one-third from private philanthropies and foundations.

Commissioner LEE. Do you think that is the way the proportion should be, generally speaking?

Mr. FORTUNE. Yes, I really feel those persons who are really to pay for services should do so in accordance with their ability to pay. We feel that we are handling now 40 percent free cases at our agency, and that is about what you would expect in this community.

Commissioner LEE. Your agency is an autonomous agency?

Mr. FORTUNE. Yes, a member agency of the Health Council, with an autonomous board.

Commissioner LEE. You are beholden to nobody how you conduct your affairs or how you spend your money after you get this money?

Mr. FORTUNE. That is right, essentially. The Board is autonomous, but we do it here through the policies and wishes of the other rehabilitation agencies and the Health Council.

Commissioner LEE. You are a nonprofit organization in the Community Chest organization, but you are independent?

Mr. FORTUNE. That is right.

Commissioner LEE. Do hearing and speech agencies have some sort of association with each other countrywide?

Mr. FORTUNE. Yes, we do in terms of research, but we feel that there are many other agencies that should be brought into this picture; medical facilities, for example, that are working aside from the ancillary facilities and which sometimes are not getting together as much as they should.

Commissioner LEE. Whose function should it be to bring those people together?

Mr. FORTUNE. I believe a survey on a national level might be advisable to see what is really being done and to try to coordinate the work of all so that there is not an unwarranted duplication of effort.

Commissioner LEE. You mean a survey under government auspices?

Mr. FORTUNE. Perhaps. On a local level I believe we should do our own survey. On a State level I think the State. However, on a national level I believe too they can coordinate a little better by a survey-type of program.

Commissioner LEE. Do you think that this scheme you have here of having an independent autonomous foundation-type of thing is the best way to meet the problem?

Mr. FORTUNE. We think the pattern here has worked beautifully, and it has been copied by a sufficient number of other States and metropoli-

tan areas that we believe it probably is a very good plan. We are reaching large numbers of people that way.

Statement¹ of

DR. MOYER FLEISCHER

Chairman, St. Louis Division

Missouri Association of Social Welfare

St. Louis, Mo.

I appear here, not as a representative of an agency or of a group actively concerned in medical care, but on behalf of an organization which is interested widely in the field of health and welfare.

What I wish to present relates to an aspect of medical care concerned with the possible restoration of the individual to some degree of economic effectiveness and to an equitable outlook on life.

Home medical care relates primarily to persons affected with chronic diseases or impairments, such as arthritis, paraplegia, cardiac disease, or syphilis. Such persons require long continued care, and if they are to be restored to some degree of useful activity they need long training and probably psychologic support.

Such home care is primarily a matter of organization of various services which already exist in the community.

First is medical service in either hospital or out-patient department, leading to diagnosis of the condition, evaluation of the patient's potentialities, and recommendation for rehabilitation.

Second, comes social study of the patient and of his home environment, keeping in mind his needs and the limitations of the home. In some cases it might be necessary to seek a foster home. Here one would be utilizing either social service or medical social service.

Third, after returning the patient to the home physical therapy must be carried forward, looking toward rehabilitation; this is to be carried out, as far as possible, in the home.

However, clinic or institutional visits may be necessary. Follow up by social service workers will be required. Dietetic advice may be needed and, throughout, medical attention and guidance must be continued.

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

Needs Organization and Integration

All of the services mentioned exist in a large community, and they do exist in St. Louis. The need is for over-all organization and integration. There would have to be a specific agency to carry out such home care, whether independent or attached to some existent functional health agency.

The reason for urging the development of such a coordinated home care for certain types of persons with chronic impairment is:

1. The value of such restoration of activity to the individual and to the community.
2. The possible reduction of the use of hospital or institutional beds.
3. The possibility of reduction of costs to the community over a period of years.

The experiment or demonstration which has been carried out in New York, of course, has shown that the costs are not too small or, on the other hand, those costs are definitely less than the costs which result from hospital care. The experiment in New York has shown that this type of home care can be highly effective.

Whether the costs of such service should be borne by private or public funds is a matter that is open to discussion. I would assume, however, that the first pilot projects in any community would be initiated under private funds. Then the demonstration—followed by experiences that have been carried out in all communities by private funds—may eventually be taken over by public agencies.

Home Care Availability

Now, as regards home care for the indigent and medically indigent, I am not ignoring the services available through publicly or privately supported hospitals, health clinics, or out-patient departments, nor the emergency services offered by the medical societies.

Actually, I am thinking of acute or sub-acute illness in the groups mentioned. Certainly, in many situations hospital care is not required and is costly. Actually, such individuals may be taken to hospitals, and for a variety of valid reasons be refused acceptance, or discharged before actual complete restoration. Such persons may need medical care, nursing care, and probably medical social service.

At one time, in some larger cities, there existed the so-called district physician, who was supposed to look after the medical needs of the indigent in

a particular geographical area. The system was pretty bad, but there is no reason why a somewhat similar system might not be developed under better conditions and control, and under the general improved social outlook of the present day. Such a system should, of course, be publicly supported.

One might suggest that in the case of a young physician recently graduated, just entering into practice and thus having a very limited practice, taking on such an obligation might be very pleasing to the individual.

In connection with both types of home care here discussed, it would be essential that the groups to be serviced should be made aware of the facilities. It is pretty generally recognized that the facilities available for the indigent are not known to the indigent. That has been shown in many studies—and here again it would be essential that some part of an education program would have to be carried out. Education would be needed if the opportunities were to be reasonably and fully utilized by those whom it would be set up to serve. Both fields discussed are probably partly covered by services available today, but the need is for organization and extension.

Statement ¹ of

MRS. WILLIAM MOORES

Chairman

Local Health Council in Ukiah, Calif.

For Mendocino County

Ukiah, Calif.

Mendocino County, with a population of some 42,000, covers an area of approximately 45 miles from east to west and about twice that distance from north to south. Geographically, it is divided by mountainous timberland into coastal and interior regions. This division, along with inadequate roads and a rapidly increasing population—both within the cities and in outlying farm and timberlands—provides the basis for most of the county's medical and health problems.

Mendocino County has 24 physicians. About 18 or 19 of these are fully active; the remainder are partially or entirely retired. This figure is exclusive of the 10 staff physicians employed at the Mendocino State Hospital at Talmage. Of the active physicians, all but three are in the cities of

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

Ukiah, Fort Bragg, and Willits. This leaves many populated areas without medical care and places an almost impossible patient load on the working physicians.

Because of the poor roads and great distances between populated areas—in some cases 30 to 40 miles—those people not residing in or near the three cities mentioned have a difficult time getting any medical care. Consequently, the accepted ratio of physicians to population of 1:1,500 is anything but adequate in Mendocino County. . . .

There are 16 dentists in the entire county. This number is far from sufficient and, as in the case of the physicians, they are clustered in the three main cities of the county. Although free dental examinations are given children entering school for the first time, little or no follow-up is possible: it is just “too hard to get an appointment.”

Hospital Shortage

On paper, Mendocino County has sufficient hospital beds. But the County Hospital, built 50 years ago, has long been classified as “nonacceptable” by the State investigators. As of June 1, 1952, great improvement has been made both in personnel and equipment in this hospital. But the physical plant remains antiquated.

The four private hospitals in this county, with a combined capacity of 97 patients, are acceptable and provide good medical care, with the exception of tuberculosis and communicable disease care. They are always full to capacity. Two of these hospitals are planning to increase facilities. Nevertheless, many patients leave Mendocino County for hospital care, going to San Francisco, Lake or Sonoma County, rather than wait for an available bed.

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One problem of Mendocino County remains untouched and unsolved: that of the migrant worker who is essential to the agriculture and lumber industries which support this county. There are an estimated 5,000 of these persons in Mendocino County who do not qualify for medical care unless they “go first-class” and pay standard hospital and physicians’ fees. Most of them are not financially able to do this.

It has been suggested that a State-wide program be inaugurated whereby these folk, if indigent, receive medical care. This care might be limited to maternity, child care, and accident care.

These problems of Mendocino County which arise from geographical causes might be lessened if more first aid stations, more physicians, and more nurses were strategically located here and if better salaries were offered to attract needed personnel in the hospitals and in the Public Health units already established.

I would like to add a few words in view of what I have heard today. We have had quite a struggle with our county hospital. It is beyond description. You have heard about it. And it makes me rather ill.

Health Department Organized

However, the Health Council in Mendocino County was formed a year ago, and we had quite a situation there. We were one of the 16 counties, I believe, that was without a health department. We do have a health department now. At the time we were organized there was no health department. The county hospital was in quite a state, to put it mildly. We had tubercular people who were entirely without care. Many tubercular patients were sent to Sonoma, but they paid for their care at Eastern Park. And Sonoma is now crowded. But the indigent tubercular patient was left completely without care in Mendocino County.

That was the situation when this council was organized. We now have put in new equipment at the hospital. But if you want to stay awake tonight you can think what would happen if a spark started out there. We have gone to considerable trouble to get a new county hospital going. We have a very fine committee working on it.

Tuberculosis Ward

We had top priority for a tuberculosis ward with this county hospital under the Hill-Burton Act recently. We were turned down because of the Bakersfield disaster. We have temporarily arranged for these tuberculosis patients to be taken care of at Redding. How long this will be going on I don’t know, whether they can take care of our patients continuously or not. In the meanwhile we have our tubercular patients, we have our county hospital, and we are holding our hands and hoping that nothing happens.

I have heard it several times today, and I would like to repeat myself. I think that in overcrowded areas where there are such desperate hospital problems that the funds from the Hill-Burton Act could be distributed a little more equitably.

We have a tremendous problem of personnel. After hearing the reports today I think we are very lucky that we have a doctor in our health department and doctor in our county hospital. But we have one sanitarium for the entire county, and in terms of mileage that means that the doctor spends half of his time in the car going up and down the county. We need at least one on the coast and one in the interior. We can't offer any fantastic salary for the sanitarium, and I don't think it is very likely we can get one soon, as desperately as we need it.

This migrant worker problem is one that I am not familiar with, but one that all of us up there realize is very important. When 5,000 out of a population of 42,000 have no legal recourse to medical aid of any kind, you cannot expect to have very good health conditions. Yet those are the people who probably need more medical attention than any others.

In actual practice, of course, in a humanitarian way, if there is a serious accident, or any such emergency, it is taken care of in the county hospital. But there is no maternal care, no child care, no preventive health care, nothing for those people at all legally unless the doctor cares to contribute his time gratis, or the county hospital takes them in, which it does in an emergency. But I think it is a very poor situation for an important segment of the population.

**Statement¹ of
MR. RICHARD HANSON**

**County Commissioner, Court House
Minneapolis, Minn.**

As Chairman of the Hennepin County Welfare Board during the past 4 years I have had the opportunity to observe and personally participate in administrative policy determinations affecting more than one-fifth of the public assistance caseloads for the entire State of Minnesota.

I have noted the problems and ever-increasing cost of providing minimum medical care for the financially indigent. The greatest rise was in hospital rates, which increased by 67 percent. Approximately one-third of our own agency's medical expenditures is for hospitalization.

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

I must, therefore, conclude, that while our assistance caseload remains relatively constant, and old-age and survivors insurance coverage expands, we are acquiring an increasing concentration of medical risk cases for lack of other means to meet the cost of medical care, and that a thorough review of inadequate Federal participation in medical care costs is imperative, if public assistance continues to be the primary resource through which the medical needs of our expanding aged population must be met.

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I might say, too, that the average age of our old-age assistance caseload has gone from 72.4 to 76.6 in the last 4 years, so that this medical care cost for these people, we find, is not only getting greater, but the length of attention needed, or time spent in hospitals, is getting longer, and the age of the people is getting older.

**Statement¹ of
MRS. RIKA MacLENNAN
Family Service Association
Cleveland, Ohio**

Have you known of distraught mothers of three or four or six children—ill, needing an operation or hospital treatment but having no friends or relatives to help out, and with too limited an income to hire help to care for the children? Have you known of an elderly couple or older person living alone too ill to shop, to cook, to clean, to provide the needed things for their living but who do not need nursing care?

Cleveland has three welfare agencies, the Family Service Association, the Jewish Family Service Association and the County Welfare Department which provide a limited amount of service in some such instances. The Family Service Association through its homemaker service provides competent, understanding trained homemakers to care for 326 children in 79 homes where mothers were ill during 1951; 4,600 days of service were provided at an average cost of \$7.46 a day during 1951. The average number of children per family was 4.1.

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

Homemaker Service

In the Family Service Association, housekeeping service on a part-time basis was given to 283 individuals in 138 different family units. Homemaker Service is a part of the Family Service Association case work program. It not only helps the ill person by relieving her of worry about the work she is supposed to do, but the reassurance of the case worker and trained family counselor and the homemaker releases her from a far greater worry about what is happening to her family while she is receiving needed medical care.

Homemaker Service is not a nursing service, neither is it a glorified maid service. Homemaker Service provides homemakers trained to take over the responsibilities of the home and to consider the general well being of the family. When help with heavy cleaning and laundry is the major need, Homemaker Service is neither the answer nor a wise use of community money. The service is available only to families who are unable to make plans of their own during time of illness. Case workers try to determine the real need and to do an efficient job in helping the family solve a complex problem with which they are overwhelmed when illness strikes.

Relieved Care Problem of Aged

Many doctors and nurses have told us that the reassurance of having a motherly person in the home to care for the children in the absence of the mother is most helpful in effecting the recovery of the mother. Even a limited amount of service has helped with the serious problem of hospital bed shortage and nursing homes for the aged, and has led many to end their days in the home they were loath to leave.

This service to older persons has amounted to an average of three or four days of service per month and has in many instances helped to prevent the breakdown of a husband and wife or wife who, single-handed, has been trying to care for the other partner suffering from such things as heart ailment, strokes, arthritis, amputation and so forth.

Jewish Family Service has a similar but smaller service than Family Service Association. The County Welfare Department, a tax-supported agency, has service for clients who are receiving financial assistance from them.

That service is largely part-time for cases of chronically ill, disabled or blind. Some tempo-

rary and part-time help is given to incapacitated mothers in cases of confinement or at time of an operation.

In community fund agencies families are expected to make repayment for the service to the greatest possible extent. However, many can pay nothing. Only 13 percent of homemakers' expenses were refunded by families during the past year.

The recommendation that I would like to make is that a study be made by the Community Planning Committee to determine unmet need in this community for Homemaker service during temporary, long-term, or chronic illnesses.

There is very little service at this time for the chronically ill. It is known to be less costly both to the community and to individuals to provide this type of home care in many instances of illness than hospital or other institutional care.

Statement¹ of

REV. O. WALTER WAGNER

Executive Secretary

Metropolitan Church Federation

St. Louis, Mo.

HEALTH NEEDS OF THE NEGLECTED AND UNDERPRIVILEGED

... I have this statement here which represents the thinking of several hundred Protestant ministers of the area. ... Pastors have a highly privileged personal relationship with the people of their parishes. The clergyman has an insight into the total needs of his parishioners possessed by few other individuals in the community. His unrestricted visitations, his intimate personal consultations, his total family contact, his religious services at birth, baptism, marriage, and death; his frequent calls in times of illness all furnish him an insight to and a knowledge of the moral, spiritual, physical and financial needs of his people. His point of view is not merely a statistical summation but a synthesis of all the emotional, psychological and physical facts.

Adequate Health Services Needed

Because pastors do have this privileged insight they are also morally obligated to minister to the

¹ Delivered at Regional Meeting in St. Louis, Mo., September 15, 1952.

needs they uncover. Clergymen are crusaders because they are conscious of the community's total needs. They are under obligation to keep privileged communications inviolate while they promote community programs to meet the needs of their people. Though this statement deals largely with the health needs of the neglected groups and underprivileged folks many of our clergymen find that adequate health provisions and adequate health services are luxury items for most of their people.

Only a small percentage of our parishioners can afford long illness. One of our distinguished clergymen encountered a long, chronic illness in his own family. Before the illness ran its course he had to employ three full-time nurses. He encountered long hospital care. When it was over his comment was: "This illness used up all my reserves. I frankly do not know how most of my parishioners could meet such an emergency. Only the total resources of my people helped me to carry this burden." There is need for wide and wise public assistance for families that meet long illness and serious accidents and emergencies.

Many people belonging to what we loosely call the middle income group neglect regular health services, periodic health examinations and regular dental care because they cannot afford it. The health services of a democratic nation are as essential to its success as are its educational services. Most of our clergy are convinced that public education and public health can be administered in a manner consistent with our democratic form of government. We are all committed to a minimum program of public school services. Ought there not be a minimum public health service that would meet the basic needs of the middle income group?

Among the low income group there is almost a total absence of preventive medical care, such as nourishing diet, regular health examination, and regular patient-doctor relationships.

Health Picture of Disadvantaged

For a more specific picture of the health conditions among the disadvantaged I asked the Rev. Carl Siegenthaler, Superintendent of Caroline Mission in the Hickory Street area for a statement.

He said in part: "To talk about the health of the people who live in the 'slum' or obsolete areas

of the city is to talk about their living conditions and to talk about their living conditions is to talk about their housing. Next to food and clothing, proper housing is the third basic necessity for the maintenance of family life and good health. The present condition of housing in the core areas of the city are fundamentally cancerous, in almost the fullest sense of that term.

"Leaking pipes from the floor above, rickety stairways, fire-traps of highly inflammable material and little egress; drafty windows and doors in houses without central heating; water in the basement; rats, mice, roaches coming and going as they please; darkness because of little sunlight down the canyon of buildings and through the scarce and tiny windows—plus a continuous tidal wave of filth piled up to the steps out of which comes sickness that saps the strength of the underprivileged.

"Add to this sordid picture the overflowing privies, the clogged rubbish and garbage containers, and the milling thousands crowded in where 10 once lived when the buildings were built and you have the basic cause of ill health among the lower third of our population.

"The best of housekeepers and parents must be specially blessed if they can keep up with the flood of these major obstacles to good health; and if they have children it is impossible."

When something finally staggers them, when they can't throw it off or outgrow it or cover it over, after everything else has been tried, disadvantaged folks collapse and are brought to the hospital—too late. Because health is still either a pearl of too great a price or a charity, many folks are denied its preventive powers. Diabetes, tuberculosis, cancer, heart disease, venereal diseases, bad teeth, and even fractures daily show up in the receiving room—too late.

To make these pitiable people in their sordid plight the victims of a program of medical care, based purely on the profit system where only those who can pay are serviced, means that decay continues and progress becomes a prisoner to profit. We believe it is not only good religion and good citizenship but good business to provide a program of health education and health services to these people out of the total public resources of the community.

Inadequate Rest Homes for the Ailing Aged

The Protestant pastor, probably more than any person in the community, is daily aware of the problem of the aged. With increased longevity, a goal to which we all aspire, comes the problem of making the sunset years happy and worth while. Public attention is rightly being focused on housing, unemployment, pension for the aging, but all these areas are still characterized by unmet needs.

Dungeons of the Dark Ages

Most pathetic is the case of the ailing aged who are not able to house themselves or who are unwanted. A limited number of excellent nursing homes are available to those able to pay, but old people accustomed to the normal comforts of cultured home life are often forced to spend their last years in so-called "rest homes."

A leading pastor of this city, after a recent visit to a rest home, described it as "something a little less than the dungeons of the dark ages." He said, "My wife and I could smell the sickening odors from the street. When we entered the house it was overcrowded, with beds so close to each other that it was difficult to walk among them. There was a commotion in the next room and we found an old lady in her eighties had fallen out of bed and lay helpless and uncared for under two beds. The inadequate help was laughing at her predicament."

Many of these rest homes are overcrowded, understaffed and devoid of any recreative or rehabilitative services. With the galloping rate of increase of people who reach the age of 65 and over the public must face realistically the need for a greatly expanded health service for the ailing aged.

High Cost of Psychiatric Treatment

Our clergymen encounter an alarming number of mentally disturbed people ranging all the way from simple frustrations to severe psychosis. The preliminary counseling a pastor gives his parishioner often uncovers a need for medical referral. The case load of the comparatively few psychiatrists is so great that only those who can meet the excessive high cost can be accommodated. There is a need for a program of public education in good mental health and a great need for psychiatric treatment at greatly reduced cost.

The Growing Problem of Alcohol

The problem of the effects of alcohol—not only alcoholism, but the regular consumption of alcoholic beverage—is one which greatly disturbs the pastor as he visits the hospital wards. Men and women who should be in the prime of life are seriously ill, and face a long period of invalidism because vital organs have been seriously injured if not partially destroyed.

... We need an adequate program of education in the reduction of the tensions which lead to drinking, adequate recreational facilities to overcome boredom, and adequate physical examinations for early detection of physical damage due to the use of alcohol. The Protestant Church has long been the champion of temperance and we will continue to call upon the Nation to face frankly the evil effects of alcohol.

Protestant Pastors as Partners

Protestant pastors for the most part are convinced that a program of health education and health services can be provided to meet these needs within the framework of our democratic institutions. Just as a public postal system and a public school system has not destroyed our democracy but strengthened it, so a program of public health can serve to preserve our national strength.

* * *

We also recognize the need for courageous and enlightened leadership on our part in such areas of counseling that are committed to us. More and more pastors are engaging in pastoral counseling, in premarital counseling. More and more of our pastors are convinced that they have a responsibility in removing the "hush hush" attitude that still surrounds sound sex education and wise and consecrated spacing of children.

Many of our pastors are active in such community health agencies as the Missouri Association for Social Welfare, The Missouri Social Hygiene Association, Planned Parenthood Association of St. Louis, the Missouri Society for Mental Hygiene and in numerous church supported hospitals and clinics.

We do not set ourselves apart as mere critics of the health needs of the Nation, but as interested partners in search for a sound and serviceable answer.

OSTEOPATHS—THEIR VOICE

Statement¹ of

DR. STEPHEN A. SHEPPARD

President-Elect

Cleveland Academy of Osteopathic

Medicine and Surgery

Fairview Park, Ohio

We are licensed by the State of Ohio as physicians and surgeons. We pass essentially the same State Board examination as the medical doctors, and upon completing that examination we are privileged to practice as physicians and surgeons.

We feel that we could contribute more to the public health and welfare problems of not only our immediate area, Cleveland, but also the State and the Nation if we had an opportunity to employ the facilities which are already provided. Each of our speakers has stressed the fact that basically the problem comes back to one of manpower. We need more men—not necessarily here in Cleveland but throughout the Nation—to attack the problems of health and welfare and actually employ the facilities which have already been provided by the public—by the taxpayers.

Our group here, although consisting of only 75 men—in comparison with the rather tremendous group which we heard Dr. Hudson speak of, 1,800 men in general practice from the other group—we feel that these two groups here in the Cleveland area and Cuyahoga County function together very well. We cooperate, or try to, and we feel that tremendous strides have been made within the past 5 or 10 years so that these two segments of the medical profession are functioning today together better than they have at any time in probably the last 50 to 75 years.

Wider Availability of Public Facilities

But there is one thing we would like to suggest to the Commission—at least for the Commission's consideration—and that is to attempt to solve a problem which exists that is, in making available to all legally licensed physicians and surgeons the facilities which have been provided by the public for the public.

We do not feel that we want to come in and depart from accepted practice; we do not want

to come in and manipulate everything, body mechanics, from a strictly manipulative standpoint.

The day of the old-time osteopathic physician who manipulated everything he saw went out with the horse and buggy. Our people treat disease in essentially the same manner that physicians and surgeons of other schools of medicine. And they have for many years.

So we feel if we had an opportunity to become more active in, for example, State-supported institutions, in the city- and county-supported institutions for purposes of research, and for helping out, we feel that we could increase the contribution we have been able to make in the past, and we feel that within the foreseeable future this will become a reality.

The question is when. We feel within a matter of possibly 8 to 10 years the two segments of this unlimited portion of the medical profession will be functioning together on all levels for the benefit of the public health and welfare.

Opportunity for Participation

Although we, in Cleveland, have only 75 men actively engaged in the practice of osteopathic medicine and surgery, we are part of a pool of 12,000 men and women on a national basis who are licensed as physicians and surgeons and who have been trained as physicians and surgeons.

Most of these people have had internships; most of them have had residency training; all of them who are in specialty practice have had residency training, and these people feel that they should have an opportunity to attend post-graduate sessions; to take part in the activities of the research program, for example, which is maintained and was built originally by tax money, and we feel that we can contribute something very real in helping to solve the problems which confront this Commission today.

I do not think any one person has the solution to this problem, but as a general suggestion or at least a thought—and I should say a personal opinion—it appears that a national council on medical education might be established, or possibly State councils on medical education, or possibly even localizing it more, since so many of us apparently have an overwhelming fear of centralization of power and supervision; e. g., some sort of a council on medical education, be it local,

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

State or national, to evaluate the graduates of the various schools of medicine, to evaluate the men who are licensed as physicians and surgeons, and determine which ones are actually eligible to take part in these programs.

I have nothing further to say today except that Dr. Hudson's comment on the care of the public health and welfare problem in this community certainly represents the views of our group. We do not agree on everything but we certainly do agree on that phase, and we are right in there pitching, as it were, to try to help in any way that we can to aid the Commission and assist the Nation to increase its facilities to combat the problems of public health and welfare.

Liaison With AMA

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Commissioner RUSSEL V. LEE. Dr. Sheppard, how far has the move for liaison gone with the AMA?

Dr. SHEPPARD. Of course, I am not in a position to speak for our national association since I am not in intimate contact with either the AOA, the American Osteopathic Association, or the AMA, but I understand—and, of course, this is hearsay through the grapevine—that there is a very real effort on a national level to effect what has been referred to as an amalgamation. We feel this would be a good thing if both segments of the profession would be allowed to retain their identity and their control over the curricula of their various schools.

The osteopathic profession is certainly willing and ready to cooperate with any group for the preservation and aid of the public health and welfare. I believe that is a thing that will come about.

The only question is, when will it come about? I think Dr. Fine of San Francisco, who last year was president of the American Medical Association, in one of his talks estimated it would require a matter of 10 years. The problem confronts us today. It may take a generation. There are a lot of members of our profession, as you know, who cling to ideas and methods which the more recent graduates are not terribly concerned about.

But I do know that our group is very much interested in that group, and I understand that the House of Delegates of the American Medical Association is equally interested.

Commissioner LEE. Would you anticipate that ultimately there will be an amalgamation of osteopathy in the general body of medicine?

Dr. SHEPPARD. I would anticipate that eventually all people who graduate from schools, who are trained as physicians and surgeons, would represent or be a part of medicine as we think of it in the general sense. The degree which these men would require or employ to identify themselves as practitioners would be for the most part secondary. In other words, whether a man has an M. D. degree or a D. O. degree would not primarily act as a deterrent either as to his functioning in acceptable institutions or as a completely trained physician and surgeon.

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Common Meeting Ground Foreseen

We feel that the D. O.'s and the M. D.'s in years to come will find a common meeting ground wherein they can function together for the public health and welfare, but at the same time retain their identity and their individual thoughts.

We feel that the question of differences of opinion within the schools of medicine is a good thing. We feel that within limitations, competition between two schools of medicine or three schools of medicine, or five schools of medicine is a good thing, insofar as the men are basically trained in a manner to treat the public in an acceptable manner.

They must qualify. They must pass the State Board examination. They must take certain specified subjects, and, of course, that is being done now.

Statement¹ of

DR. ROGER E. BENNETT

President

**Ohio Osteopathic Association of
Physicians and Surgeons**

Columbus, Ohio

With respect to your search as to figures on health personnel, I wish to inform the Commission that there are 551 osteopathic physicians licensed and practicing in Ohio, or approximately 1 per 12,500 population. Of Ohio's 88 counties, 77 have

¹Delivered at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

at least 1 osteopathic physician in active practice; 22 counties have 4 to 10 osteopathic physicians in practice; 8 have 10 to 50; and 3 have over 50. We have demands from all sections of the State stressing the need for more osteopathic physicians from communities both small and large.

I point out that approximately 50 percent of the osteopathic physicians are located in or near metropolitan areas in which there is an osteopathic hospital open to the osteopathic physician for the care of his patients. The concentration in a few cities is, we realize, detrimental to the overall health needs of the Ohio public. It can be said, however, that the osteopathic profession has been forced to such a distribution largely through circumstances over which our profession has no control.

Bed and Nursing Shortage

At the present time, in the State of Ohio, there are 11 osteopathic hospitals serving the profession in caring for the public health needs of the State. These hospitals contain a total of 600 beds. Some 20,000 Ohio citizens in need of hospitalization are being cared for annually in our osteopathic institutions.

A recent survey among osteopathic hospitals in Ohio indicated that our institutions need at least a 20 percent increase in the overall bed capacity to accommodate the demands of the Ohio public utilizing our facilities. There is a current shortage of approximately 25 percent in nursing personnel in our hospitals, and a 15 percent shortage in trained technical personnel.

Denial of Hospital Rights

In reference to the degree by which Ohio hospitals meet the needs of the existing population, I would point out a situation here in Ohio which is a distinct handicap to the osteopathic physician in caring for his patients. About 30 to 40 percent of the osteopathic profession in Ohio is without access to hospital facilities and about 90 percent of the entire profession is denied access to tax-supported hospitals.

Residents of Ohio who are patients of osteopathic physicians and surgeons are denied the opportunity of being attended by their osteopathic physician in most Ohio hospitals. These same residents supported these hospitals by their taxes, and their services are available only on the terms that the patients shall surrender their choice of

physician and surgeon, unless the physician and surgeon shall be a doctor of medicine, with the degree M. D.

This situation exists in spite of the fact that under State law the legalized scope of practice of osteopathic physicians and surgeons is comparable to that of the physicians and surgeons of any school of medical practice. In support of this, I quote the following ruling of the Attorney General of Ohio (1946 O. A. G., page 743, opinion No. 1350) :

An examination of the Medical Practice Act (Secs. 1262 to 1294, General Code) as last amended in 1943 discloses that the legislature has provided for the establishment of three main branches of practice. One branch is referred to as "medicine or surgery," another as "osteopathic medicine and surgery," and a third as "limited branches of medicine or surgery."

Under the present statutes a doctor of osteopathy must possess substantially the same qualifications and pass substantially the same examination as a doctor of medicine, and once having passed the examination, can practice medicine or surgery without limitation so that as a practical matter these two branches may be classified as one single unlimited branch under the amended statutes.

I call this to the attention of the Commission to emphasize that the apparent shortage of physicians and the lack of proper medical care on the part of a considerable segment of the State population is due to this denial of hospital rights to citizens who are the patients of osteopathic physicians and surgeons. The condition stands as a part of the picture of adverse influences injurious to the Nation's health, and it is for this reason that we make this point in our testimony.

Prepaid Insurance Advocated

As to the adequacy of present health insurance plans and the extent to which people are able to afford adequate medical care, the Ohio Osteopathic Association advocates strongly the principle of prepaid insurance. Osteopathic physicians are prepared to cooperate on all such prepaid insurance plans, provided the traditional physician-patient relationship shall remain inviolate, and freedom of choice of physician of whatever licensed school of medicine is preserved, and freedom to participate or not is guaranteed to all such licensed physicians.

* * * * *

Dr. BENNETT. May I take this opportunity to submit a report of the Joint House and Board Committee of Atlantic City in our National Con-

vention of July concerning your question on amalgamation of the two professions?

Commissioner RUSSEL V. LEE. Yes, we would like to have that.

* * * * *

Statement¹ of

DR. WILLIAM A. BRANDT

Pennsylvania Osteopathic Association

Philadelphia, Pennsylvania

There are 1,038 osteopathic physicians licensed and practicing in this State, approximately one per 10,000 population. Some 50 percent of the profession is located in cities of 100,000 or more. About 25 percent of the profession is located in towns of 10,000 or less. The remaining 25 percent in cities 10,000 to 100,000.

In order to obtain a license to practice as an osteopathic physician and surgeon, which includes the right to practice osteopathic manipulation, drug therapy, and major operative surgery, the State law requires that the candidate shall have had not less than 2 years preprofessional college work with specific requirements in physics, chemistry and biology; 4 years in an approved college of osteopathy, and internship in an approved inter training hospital.

Inasmuch as the osteopathic profession is located in some 230 cities and towns in the State, almost all of which are without the facilities of local public health units, we advocate, in the interest of preventive medicine, the establishment of local public health units in all areas which are not currently sufficiently served by the present facilities. Legislation passed by the 1951 General Assembly of Pennsylvania makes adequate provisions for county and joint county health units. However, progress has been slow, and to date only one pilot unit has been organized. Progress cannot be speeded unless the people of the State are educated to an awareness of the value of public health units, and will vote to tax themselves to raise the necessary operating funds, and until sufficient personnel can be trained to staff these units.

* * * * *

In the procurement of professional personnel, particularly physicians, it is notable that very

few positions in the field of public health offer much incentive to the average young physician to leave his practice and take the necessary training and devote his life to a career in public health. The Federal government and the separate States have an obligation to increase the salary scale of full-time salaried personnel and to establish equitable merit and retirement plans.

Osteopaths in Public Health

We wish to emphasize the fact that no licensed physician should be refused an opportunity to follow a career in public health, and we strongly urge the elimination of existing discriminations against doctors of osteopathy. Many capable physicians could come from the ranks of this profession to alleviate the shortage of personnel, if they were afforded equal opportunities for post-graduate training.

There is a crying need for personnel trained in the scientific methods of medical research, both basic and applied. The pecuniary inducements of private practice to persons with the proper aptitudes for scientific research constitute a handicap to the supply of entrants in the research field that can only be counteracted by public stipends which will enable the proper scale of subsistence to persons adapted to dedication in the field of research. We believe that the State should follow the lead of the National Science Foundation in providing such financial assistance. The cost of laboratory and other research facilities is prohibitive to most research institutions, including the Philadelphia College of Osteopathy.

* * * * *

In the matter of the degree to which clinics and hospitals meet the needs of the existing population, we are compelled to point out that 40 to 60 percent of the osteopathic profession in the State of Pennsylvania are without access to hospital facilities, and the entire osteopathic profession is denied access to tax-supported hospitals.

Hospital Facilities Denied Patients

Citizens of the State of Pennsylvania who are patients of osteopathic physicians and surgeons are denied the use and comfort of their physicians in the Pennsylvania hospitals, which they support by their taxes, and which are available only on the terms that the patients shall surrender their choice of physician and surgeon, unless the physician and surgeon shall be a doctor of medicine, not-

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

withstanding the fact that under State law the legalized scope of practice of osteopathic physicians and surgeons is comparable to the physicians and surgeons of any school of medical practice.

The shortage of physicians and the lack of proper medical care on the part of a considerable segment of the State's population are due to this denial of hospital rights to citizens who are the patients of osteopathic physicians and surgeons.

This is primarily a matter for correction at the State level, but the current resultant condition is a part of the picture of adverse influences injurious to the Nation's health, which are believed to be of interest to the President's Commission in collecting and assaying the facts.

Principle of Prepayment Advocated

The spectre of medical and hospital costs for unpredictable illness stalks the average individual, and we advocate the principle of prepaid insurance for such purposes. In Pennsylvania the combined services of the Blue Cross and Blue Shield organizations have gone a long way to provide this insurance, although the extent of the coverage is far from complete. We are prepared to cooperate on a local, State or national basis to attain a more complete coverage, provided, as in the Blue Cross and Blue Shield plans in Pennsylvania, the traditional physician-patient relationship shall remain inviolate; freedom of choice of physician of whatever licensed school of medicine should be preserved, and freedom to participate or not should be guaranteed to all licensed physicians.

By such advocacy, the osteopathic profession does not seek to escape its responsibility to care for the sick and wounded regardless of financial circumstances. The insurance principle encourages all persons to seek timely advice and attention which they are reluctant or fail to seek to the detriment of the collective health in the absence of the application of the insurance principle.

Financial Assistance

With regard to the desirable level of Federal, State and local government health expenditures, we have already advocated an increase in expenditures for medical research purposes and for purposes of local public health units. In addition, we advocate public financial assistance to institutions training physicians and surgeons.

Inasmuch as the graduates of these institutions are eligible and do qualify for practice in States

generally, without regard to the location of the training institutions, and inasmuch as there is reportedly a scarcity of physicians in States beyond the productivity of the schools located in those States, it appears logical for the Federal government to manifest an interest in the preservation and extension of adequate training institutions. Any Federal interest should be manifested with proper safeguards for maintaining the right of the institution against any dictation or interference relating to its curricula or process of training.

Tuition in osteopathic, as in other medical colleges, accounts for only 25 percent of the costs. The remainder constitutes a nightmare of dependency on contributions and clinical fees. Medical schools connected with State universities get subsidies from State revenues, but the osteopathic schools and many medical schools do not receive subsidies from any State revenues, and they are the institutions which are the hardest hit during these times of advancing costs of building and equipment and faculty salaries.

We believe that the first responsibility for health needs devolves on the individual, then on his local government, then on his State government, and, if need be, the first three proving inadequate, the Federal government—in the areas, first, of medical research; second, of professional education; and third, of establishment of health units.

**Statement ¹ of
RALPH COPELAND, D. O.
President
California Osteopathic Association,
Los Angeles, Calif.**

We are a health service organization and our principal work has been directed toward improving ourselves and our institutions in a continuous effort to provide improved health care for the people of this area. We have not had either the finances or the personnel to make an adequate survey of the economic problems of health care.

It has long been our contention that a considerable segment of the population fails, for one reason or another, to receive adequate medical and hospital care. It has also been our contention that all parties concerned—the physician, the nurse, the

¹ Delivered at the Regional Hearing in San Francisco, Calif., September 29, 1952.

employer, the employee, and the government representative—should cooperate and work together in an attempt to provide a mechanism whereby all persons can be assured of adequate medical and hospital care. In attempt to attain these objectives, it seems to us that our primary effort must be directed toward increasing, improving, and making more readily available adequate hospital facilities, medical teaching institutions, and medical teaching personnel.

Osteopathic Profession in California

I would like to give you a little information and background of the osteopathic profession in California.

COLLEGE. We have one college in California, the College of Osteopathic Physicians and Surgeons. It is a nonprofit institution located in Los Angeles. It was established in 1914 through the amalgamation of the Pacific College of Osteopathy and the Los Angeles College of Osteopathy, which, in turn, were founded in 1896 and 1905, respectively.

The present student body numbers 355; present facilities permit enrolling about one-half of the students who make application for admission. Three years preprofessional work in an accredited college is required for admission. . . . The professional curriculum includes 164 weeks, extending over a period of 4 years and totalling 5,838 academic hours. The school contains 17 academic departments. There are 204 persons on the faculty—20 of whom are full-time faculty members, 29 are part-time paid members, and there are 155 part-time volunteer faculty members.

The college is presently operating on an estimated annual budget of \$600,000. This budget is being met by student tuition fees, clinic fees, and professional and lay contributions. The finances of the school are greatly augmented by volunteer teaching services by members of the osteopathic profession.

Profession Contributes Support

The college has had very little outside financial assistance. For the past 2 years the Federal government has given the college a grant of from \$20,000 to \$25,000 a year for use in the cancer teaching program. In order to keep this school operating, our profession has contributed approximately \$65,000 annually during the past ten years. We feel that there is a definite need for more teaching personnel and for more plant equipment.

We also feel that there is a need for more research; however, our funds are very limited and our profession is now contributing more per capita than any other professional group. We feel we must explore other areas for additional funds to increase our teaching staff and our research program.

Hospital Facilities

HOSPITALS. In California, there are 38 hospitals staffed by members of the osteopathic profession. They are located in 26 communities and provide 1,554 beds. There are 11 hospitals providing 69 internships and 2 providing residencies. Scattered throughout the State are community, county, and district hospitals which have both M. D.'s and D. O.'s on the medical staff. Some of these hospitals have dual staff arrangements and some have a single medical staff composed of both doctors of medicine and doctors of osteopathy.

The use of Federal funds provided by the Hill-Burton Act has resulted in the construction of hospitals in many areas previously devoid of these facilities. The building and operation of these hospitals is now attracting better trained physicians to the rural areas, which we believe is a very desirable thing. We believe adequate hospitals should be available to all of the people at a distance not to exceed 1 hour's driving time by automobile. We further believe that these citizens should not, by hospital rule and regulation, be denied the right to have their own physicians as long as they be competent and ethical.

Licensure

There are 2,116 graduates of osteopathic schools licensed and practicing in California. They are functioning in 269 different communities. The law providing for unlimited practice rights in California is contained in Chapter 5, Division 2, of the Business and Professions Code. It provides for a Board of Medical Examiners to administer the act for graduates of schools granting the M. D. degree, and a Board of Osteopathic Examiners to administer the act for graduates of schools granting the D. O. degree. The educational and other requirements for licensure contained in this code apply to graduates of all schools, regardless of degree. In other words, there is only one physician's and surgeon's certificate in California, and the requirements for licensure are the same whether the applicant has the

degree of doctor of medicine or of doctor of osteopathy. . . .

Professional Activities

Members of the osteopathic profession in this State are functioning as county and city health officers. They also serve on the California State Board of Health; the California State Hospital Advisory Committee; the California State Hospital Inspection and Licensing Committee; the California Crippled Children's Advisory Committee; and on various city health commissions.

In our opinion the responsibility for enacting social and economic legislation lies with our State and national legislative bodies. The effective development of this type of legislation necessitates consultation with all classes of people. In the matter of legislation involving health problems, we feel the osteopathic profession should be consulted and should be included. We have in the past offered, and will continue to offer, our co-operation to all interested groups concerned with health problems. We are vitally interested in evolving a mechanism which will insure adequate medical and hospital care for all the people and guarantee these people the right of the free choice of physician.

Statement¹ of

LAWRENCE D. JONES

Executive Secretary,

**Missouri Association of Osteopathic
Physicians and Surgeons,**

Jefferson City, Mo.

* * * * *

There are 1,132 osteopathic physicians licensed and practicing in this State, approximately one per 3,493 population. We suggest that all surveys and statistics presented to the Commission concerning health needs be checked to determine if the health services of the osteopathic profession are included.

In order to obtain a license to practice as an osteopathic physician and surgeon in Missouri, which includes the right to practice manipulative therapy, drug therapy, obstetrics, and major operative surgery with instruments, the applicant for such license shall show satisfactory evidence that his diploma was granted on personal attendance

and completion of the course of study in an osteopathic college recognized as reputable by the Missouri State Board of Osteopathic Registration and Examination. Although not required to do so by statute, recognized osteopathic colleges all require at least 2 years of premedical training, and several require 3 years of such premedical training. Currently the majority of applicants hold academic degrees. By statute, the Missouri board is required to examine applicants in certain specific subjects, including the basic sciences and such other subjects as the board may require.

Osteopathic Physicians Well Distributed

The osteopathic physicians in Missouri are well distributed over the State, and of the 114 counties only 5 have no osteopathic service. A few years ago a survey compiled by the Missouri Farm Bureau Federation and the Department of Rural Sociology of the University of Missouri disclosed that the number of medical doctors in rural practice in the State of Missouri has been declining during the past 40 years.

Thus, a comparison of the number of D. O.'s in rural practice, as compared with the number of M. D.'s, indicates many rural counties in which there is a preponderance of osteopathic service and many in which, according to the survey, medical services are greatly curtailed because of the advancing age of the remaining practitioners of medicine. The recently issued directory of the Missouri Medical Board shows that of the 4,463 M. D.'s in the State 3,308 are located in the urban counties of St. Louis, Buchanan, Jackson, Greene, and Jasper. Thus 74 percent of the medical practitioners are concentrated in the large cities.

In these same urban counties there are 512 D. O.'s of the total 1,132, with the remaining 620 in practice in the rural areas. Therefore, a larger percentage of D. O.'s are caring for the health of the rural areas of Missouri, and thus render a distinctive service in this State.

Hospitals

Although there are several tax-supported city and county hospitals jointly staffed by osteopathic and medical doctors in Missouri, there are also 52 hospitals under osteopathic management and ownership rendering complete health services. In 1951, 42 osteopathic hospitals with the total of 1,433 hospital beds served 47,197 patients. These some hospitals reported 6,706 births. The mortality rate in these hospitals was 2.3 with the aver-

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

age patient stay—including new—8.7 days. Hospital service under osteopathic management follows the general service of the profession in that most of them are located in rural areas. In the urban counties above referred to there are only 13 osteopathic hospitals.

Thus, it will be seen that a large share of the hospital service of the osteopathic profession is in the rural areas of the State. It is these areas that have had the focus of attention by Government and all agencies interested in health problems.

The distribution of the Hill-Burton aid, giving priority to rural development, indicates that here the greatest needs exist. It may be pointed out in passing, also, that Hill-Burton funds were made available in the construction of the new \$1,200,000 teaching hospital of the Kirksville College of Osteopathy and Surgery.

Osteopathic Colleges

Of the six recognized and approved osteopathic colleges, two are located in Missouri—the Kirksville College of Osteopathy and Surgery and the Kansas City College of Osteopathy and Surgery. They have a total enrollment in excess of 700, graduating between 175 and 200 doctors per year. While these graduates are distributed widely over the Nation, Missouri continues to be a leading State in supplying students in these colleges and, therefore, many find practice opportunity in this State.

* * * * *

Health Units

It should be pointed out that the members of this profession have given aid throughout the State in helping to create a favorable atmosphere for the formation of health units. Health unit service has been aided to a degree through the establishment of the rural health clinics used in the teaching program of the Kirksville College. These clinics, adequately supervised, are established in certain adjacent counties to the college, and while providing practicable teaching experience in the training of country doctors, they also have contributed to the relief of the doctor shortage.

* * * * *

Restrictions

Restrictions, born of discrimination, deny full participation to all those qualified graduates of both osteopathic and medical schools. All tax-supported institutions ought to be available to all qualified graduates in the healing-arts field. While we feel that the present economic situation in the medical colleges necessitates a form of Federal subsidization to replace waning public contributions and endowments, the desirability of such a program is held in question.

Federal Grants for Research

There is a crying need for personnel trained in the scientific methods of medical research, both basic and applied. The pecuniary inducements of private practice to persons with the proper aptitudes for scientific research constitute a handicap to the supply of entrants in the research field that can only be counteracted by public stipends which will enable the proper scale of subsistence to persons adapted to dedication in the field of research.

We believe that the State should follow the lead of the National Science Foundation in providing such financial assistance. The cost of laboratory and other research facilities is prohibitive to most research institutions. The Kansas City and Kirksville Colleges of Osteopathy and Surgery are currently receiving grants from the National Institutes of Health of the Federal Government for improvement in cancer teaching. These grants are not coupled with any right of the Federal government to dictate administrative policy.

These colleges are also beneficiaries of grants in research from the Navy, the Public Health Service, and the American Osteopathic Association. The Navy has recently renewed its allotment in research to the Kirksville College. We advocate more such grants, but we believe the State should participate and take the initiative in fostering aid to medical research.

Denial of Hospital Rights

... In spite of the excellent work being done and the many hospitals in existence under osteopathic management, we are compelled to point out that a large percentage of the estimated 1,200,000 people of this State dependent upon osteopathic health services are denied their full rights in tax-supported hospitals for which they themselves are being taxed. The shortage of

physicians and the lack of proper medical care on the part of a considerable segment of the population is due to this discriminatory denial of hospital rights to citizens who are the patients of osteopathic physicians and surgeons. This is primarily a matter for correction at the State level, but the current resultant condition is a part of the picture of adverse influences injurious to the Nation's health. We believe it to be of interest to the President's Commission in collating the facts.

The specter of medical and hospital costs of unpredictable illness stalks the average individual, and we advocate the principle of prepaid insurance for such purposes.

Osteopathic Hospitals Denied Blue Cross

In Missouri the services of Blue Cross have progressed as in many other States, but in Missouri, different from the case in most other States, Blue Cross does not admit osteopathic hospitals to membership. Patients admitted by osteopathic physicians in hospitals approved by Blue Cross, and also patients admitted to osteopathic hospitals holding Blue Cross contracts, are currently being paid a flat fee of \$7 a day, this being the so-called emergency rate. This is wholly inadequate and is a further result of discrimination.

We are prepared to cooperate on a local, State, or national basis for the attainment of such an insurance objective, provided the traditional physician-patient relationship shall remain inviolate and freedom of choice of physician of whatever licensed school of medicine is preserved and freedom to participate or not is guaranteed to all such licensed physicians. By such advocacy, the osteopathic profession does not seek to escape its responsibility to care for the sick and wounded regardless of financial circumstances.

* * * * *

Tuition in osteopathic, as in other medical colleges, accounts for only approximately 25 percent of the costs. The remainder constitutes a nightmare of dependency on contributions and clinical fees. Medical schools connected with State universities get subsidies from State revenues, but the osteopathic schools and many medical schools do not receive subsidies from any State revenues, and they are the institutions which are the hardest hit during these times of advancing costs of building, equipment, and faculty salaries.

**Statement¹ of
MISS R. IDTSE**

Vice President

Minnesota State Osteopathic Association

There are 93 osteopathic physicians licensed and practicing in this State, approximately 1 per 32,100 population. Thirty-nine percent of the profession is located in towns of less than 10,000; 31 percent in cities of 100,000 or more; and 30 percent in cities of 10,000 to 100,000. Because of our limited practice law, our recent graduates are not coming to our State, thus depriving our citizens of available physicians.

In order to obtain a degree to practice as an osteopathic physician and surgeon, our colleges require that the candidate shall have had not less than 2 years' pre-professional college work, with specific requirements in physics, chemistry, and biology; 4 years in an approved college of osteopathy, and internship in an approved intern-training hospital.

Local Public Health Units

Inasmuch as the osteopathic profession is located in 46 cities and towns in the State, a number of which are without facilities of local public-health units, we advocate, in the interest of preventive medicine, the establishment of local public-health units in all areas which are not currently sufficiently served by the present facilities. We believe the establishment and maintenance of such units is the responsibility of the State and the locality involved.

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In the matter of the degree to which clinics and hospitals meet the needs of the existing population, we are compelled to point out that 98 percent of the osteopathic profession in the State of Minnesota are without access to hospital facilities, and that in most States the profession is denied access to tax-supported hospitals.

Unequal Practice Law

The shortage of physicians in this State is due in part to the arbitrary imposition of unequal practice law. This is primarily a matter for correction at a State level, but the current resultant condition is a part of the picture of adverse influences injurious to the Nation's health, which is believed to be of interest to the President's Commission in collecting and assessing the facts.

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 22, 1952.

Part III

MEDICAL CARE: ITS PROVISION AND PAYMENT

MEDICAL FACILITIES

HOSPITALS

Statement¹ of

MR. JOHN KELLEY

Division of Rural Sociology
University of Minnesota
Department of Agriculture
University Farm
St. Paul, Minn.

Because of the limitation of time, this oral report will be devoted entirely to studies of Minnesota hospital facilities and physicians, conducted by Dr. Lowry Nelson of the Department of Rural Sociology at the University along with some additions and revisions of my own.

First, the hospital facilities of Minnesota:

Minnesota, with $4\frac{1}{2}$ general hospital beds per 1,000 population—and this is just for the general hospital beds—ranked considerably above the average of 3.9 for the country as a whole. The range went all the way from $8\frac{1}{2}$ for the District of Columbia to 2.2 for Alabama. For a comparison with other States in this area: Montana ranked in third place with 6 beds per 1,000; North and South Dakota tied in seventh place with 5.2 each; Wisconsin in twenty-third place with 4.2; and Iowa in thirty-fifth place with 3.3 beds per 1,000—just below the United States average.

Available Hospital Beds

It is important to note the degree of use of available beds. Ranked in order of availability, as above, the proportion of beds in use was:

Montana, 64 percent.

North Dakota, 65 percent.

South Dakota, 68 percent.

Minnesota, Wisconsin and Iowa, 77 percent.

For these States it seems that the proportion of beds in use is in inverse ratio to the number of beds available for use. This does not, however, necessarily follow for other areas of the country.

The availability of general hospital beds in Minnesota has been increasing steadily from 4.1 per 1,000 population in 1930, to 4.5 in 1950. At the same time, there has been a very slight tendency toward urbanization of general hospitals, with 7 percent of the beds being located in predominantly rural counties in 1930, and only $5\frac{1}{2}$ percent in 1950.

This trend may be further illustrated by the fact that, in 1948, there were 6 general hospital beds per 1,000 in counties with less than 20 percent rural farm population; 5 per 1,000 in counties with 20–40 percent rural farm population; 3 per 1,000 in counties with 40–60 percent; and only 2 beds per 1,000 in counties with over 60 percent rural farm population.

General Hospital Beds

The following conclusions as of 1950 may be drawn:

First, general hospital beds in Minnesota are concentrated in the urban areas, with 64 percent located in the four counties of Hennepin, Ramsey, St. Louis, and Olmsted; and $94\frac{1}{2}$ percent in 56 counties having 1 or more urban places. That is a place of 2,500 population or greater. Only $5\frac{1}{2}$ percent of these hospital beds are located in the 20 predominantly rural counties, and 10 Minnesota counties have no hospitals at all.

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

Two, small hospitals have declined in number in recent decades, but there were still 20 in 1950 having 15 beds or less. This is considerably below the minimum of 50 which is usually considered necessary for efficient operation.

Third, the number of general hospitals remained about the same from 1930 to 1948—155 and 161—but the number of beds increased by 28½ percent. Meanwhile, the population of the State increased by only 16.3 percent.

And lastly, Dr. Nelson concluded, in 1950, that:

Hospitals are used more completely now than they were earlier—from 62 percent in 1930 to 80 percent in 1948—and the increase in percent of beds in use in the rural areas is significant in that it reveals the farm people have accepted more readily the use of available hospital facilities, other than as a last resort. This increase also indicates the growth of hospitalization insurance plans among the farm people.

Number of Physicians

Secondly, as to the number of physicians in Minnesota. The number of physicians in Minnesota increased steadily from 2,270 in 1912 to 3,883 in 1949, an increase of 72 percent. This includes only the licensed physicians and surgeons, not the osteopaths, chiropractors, or other practitioners, and it includes not only the practicing physicians and surgeons, but those in hospitals, VA hospitals, and so forth, so that all of these physicians are not available, of course, for general service to the public.

... As was the case with hospital facilities, the decades brought a continued urbanization of doctors. Whereas 24 percent of the physicians in Minnesota in 1912 were located in places of less than 1,000 population, only 8 percent, or one-third as large a rate, of the doctors in 1949 were practicing in these rural areas. On the other hand, 84 percent in 1949, in contrast to 62 percent in 1912, were practicing in places of 2,500 population or over, defined as urban.

Urbanization of Medical Practice

One-doctor towns declined from 243 in 1912 to 133 in 1949; 2-doctor towns from 104 to 93; and the number of incorporated places with no doctor at all rose from 177 in 1912 to 379 in 1949.

The most significant conclusions which Dr. Nelson derives from his study of Minnesota physicians are:

First, since 1912 the percentage of physicians in small towns has decreased, while the percentage of physicians in cities has increased.

Second, medicine has become practically an urban profession, with 84 percent of the physicians in the State now practicing in places with 2,500 population or greater.

Third, the areas of the State which have the highest proportion of farm population also have the least doctors to serve them.

Fourth, those counties having fewer physicians in proportion to their population show a slight tendency to have a lower level of living.

Fifth, those counties having more people for each physician are more sparsely settled. That is, where there are few doctors for the population, these doctors also have to serve a larger geographical area.

Sixth, although it is reasonable to assume that the people in the less prosperous, sparsely settled, rural areas of the State need medical services as much as those people in other parts of the State, they are not as accessible to such services as the urban people.

Statement¹ of

DR. KARL S. KLICKA

**President, Minneapolis Hospital Council
Minneapolis, Minn.**

HOSPITAL REPLACEMENT PROBLEM

Minneapolis is faced with a major hospital replacement problem, and is meeting this challenge in an unusual and interesting manner. As would be expected in a city of this size, a number of small to medium sized hospitals have been developed during the years of the growth of the city. As the demands for increased beds and expansion of services arose during and following the war years, it was only natural that those hospitals which were the smallest and the oldest should have the greatest desire to enlarge or replace their hospital facilities. Before this occurred, however, a representative group from eight hospitals formed what has come to be known as the Hennepin Hospital Center, Inc.

The purpose of this group was to explore the idea that these hospitals could perhaps find some method of pooling their services and sharing their costs in a voluntary cooperative method, and by

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

so doing avoid certain duplications of facilities resulting in increased cost to patients for hospital care.

Minneapolis Business Men Sponsor Survey

A study performed by James A. Hamilton Associates was financed by interested Minneapolis business men, who formed a group for this purpose. . . . Their report, published in June, 1950, evoked city-wide, State and even a Nation-wide interest. The report recommended the development of several hospital centers in the metropolitan area wherein hospitals would integrate their services in a cooperative manner in an effort to improve hospital service, and at the same time reduce their over-all cost of operation.

To quote from Mr. Hamilton's covering letter, he states:

Cooperation and New Methods

During these days of increasing hospital costs and of understandable concern over the continuance of the voluntary system of providing hospital care it is hopefully significant that a group of private citizens would undertake this study. While demonstrating a faith that private endeavor will not fail when shown the need, to undertake its proper responsibilities of providing for the sick your group believes that changing conditions demand greater cooperation and new methods of organization in the hospital field.

The original report . . . did not, however, spell out in detail the organization of any particular "Center." On the basis of greatest immediate need, the Hennepin Hospital Center, which involved eight hospitals, was selected for further study. This report was completed in January, 1952, in the form of a program and plot plan for the "Center."

The cost to the community of this phase of the program will approach \$13 million. Although this may appear to be a large sum, it represents a \$2.5 million saving in capital costs, were the same facilities to be developed individually by the various hospitals involved. Further, the annual savings in operating costs will conservatively approach the sum of \$960,000. This last factor is of the greatest significance, because of the tremendous total savings over the years.

This report has been accepted by the hospitals concerned, and at present fund raising firms are studying the area in preparation for a capital fund campaign.

Statement¹ of

MR. ROBERT WISHART

**Member Minneapolis Board of Public Health
Minneapolis, Minn.**

The problem of health and hospitalization for individuals is an ever-increasing problem in terms of finances. Very few, if any, individual working men and women can afford any prolonged illness without either (1) digging deeply into savings, which in most cases he does not have, or (2)—which I believe is the prevalent one—going very deeply into debt.

You know, of course, that without unemployment insurance—and this is the condition of most employees—a man's income immediately stops when he must leave his job due to illness. He, therefore, has a double drain—no income, and at the same time a tremendous daily financial burden of hospitalization and doctor bills.

Hospital Bills

Hospital bills range anywhere from \$15 to \$30 a day, depending upon the type of room, type of illness, whether or not a lot of drugs must be used, whether there is an operating room, and so forth. This I don't believe I have to verify with any particular figures, although I have them available from my own family's example just recently.

Now, this does not include the physician's or the surgeon's bill.

Under these conditions, many health problems, such as elective surgery, are not taken care of. As a result, millions of American citizens are not in good health, simply because they do not have the financial means. In other words, I don't believe you can buy your way into good health.

Hospital Survey

I have with me here my only copy of a report called, "A Hospital Plan for Hennepin County, Minnesota," made by James A. Hamilton and Associates. This survey was made by this organization of hospital consultants in Minneapolis on June, 1950—it is the latest report—and analyzes the current hospital needs, and future needs of our community. I believe it is a very constructive program for our community, but again it points up the financial problems involved. Let me quote from page 45 of this report:

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

Minneapolis General Hospital. This is an existing municipal operating facility of 574 beds. . . . We propose that this unit become a regional hospital center and construct, by 1955, 477 new beds.

And then this report goes beyond 1955 and talks about further needs for the future. The report further states that the Minneapolis City Hospital "even for present needs . . . is inadequate."

Further quoting the report on the Minneapolis General Hospital:

Much of the equipment is old and obsolete. The laboratory and X-ray service are extremely crowded.

This Minneapolis City Hospital, except for two new wings, is from 36 to 63 years old. Maintenance and needed repair costs have run over \$1 million in the last several years. In other words, not only is the hospital inadequate, due to its age, but it is expensive for the city of Minneapolis to operate that kind of hospital.

A new hospital is needed; but the problem is one of funds, because Minneapolis has a financial problem at the present time, even without the construction of a new hospital. It may very well be that we should have a county hospital in this area. That matter is now being thoroughly studied.

For the county to enter into the construction of a new general hospital at the present time would likewise entail that financial problem for the county. As a matter of fact, the county does not have the power under the law to construct such a hospital facility. It would entail some enabling legislation on the part of the State legislature to make that possible. This problem is now being studied, however, but it will still entail a very great financial outlay which cannot very well be met through property taxes.

According to the Hamilton survey in 1950, by 1955 the shortage of general and allied special beds would be 1,322 and 2,340 in 1970. To meet this emergency construction would cost the community, both by private and public hospitals in this county, a total of some \$19 million. The proposal is that \$8 million of this come from Federal funds and \$2 million from city funds, with over \$8 million coming from voluntary gifts.

As of now our community does not have this kind of money available. You will note that I have not tried to draw any conclusions with respect to the solution of this problem. I have merely tried to point up certain facts of the problem of our local government and our individual citizens concerning health needs in this area.

Statement¹ by

E. E. SALISBURY

Executive Vice-President

California Hospital Association

Speaking for and on behalf of the California Hospital Association, an organization representing 304 institutional members constituting 40,515 beds or a total in excess of 85 percent of the registered acceptable hospital beds in the State, it is my intention to restrict my comments entirely to the problem of the acute inadequacy of hospital facilities.

The magnitude of the problem becomes evident when it is realized that the depreciated value of hospitals in California today is approximately one-half billion dollars. It is understandable that replacement costs would be double or triple such an amount.

There is, at the present time, in excess of 140 applications on file with the State Bureau of Hospitals, the official agency for the administration of the Hill-Burton program, the total cost of which would be in excess of \$150 million, requiring approximately \$50 million in Federal funds to provide one-third of the cost.

California Fails to Keep Pace

Although approximately 20,000 hospital beds have been built in California since World War II, only 3,000 of which received any financial assistance under the hospital survey and construction program, California has, because of its phenomenal increase in population during the past decade, not only failed to improve its position, but has also failed to keep pace with the conditions in existence prior to World War II. In addition to the population factor, the increased demand for hospital services resulting from the new miracle drugs and the advancement in medical science and techniques under the impetus of the recent war have contributed greatly to the severe situation in which we find ourselves today.

It is respectfully suggested that when consideration is given to the renewal or extension of the present Hill-Burton construction program, which will expire in 1955, the existing formula for allocation of funds be carefully reviewed. Allocation of funds is now determined on the basis of the population and per capita income of the states.

¹ Delivered at Regional Hearing in San Francisco, California, September 29, 1952.

However, per capita income has a much greater importance than population because the per capita income factor is squared in the formula. Supporting data, with comparative analysis of the relationship of per capita income and rapidly increasing population for various states as it is reflected under the existing formula, emphasizes the inequities which are bound to occur.

Huge Sums Necessary

In California, huge sums must be invested in the next several years to meet the needs of a rapidly increasing population, yet the State receives very limited funds for this purpose because of its relatively high per capita income. Under these circumstances, California communities are taxed heavily to support the Hill-Burton program and also must finance locally most of the hospital expansion occurring in the State.

Statement¹ of

DR. JOHN A. FERRELL

**State Medical Care Commission
Raleigh, North Carolina**

The North Carolina cooperative hospital schedule started on July 1, 1947, when State, Federal and local funds first became available. The hospital beds available then for mental, tuberculosis and crippled children and for patients in local general hospitals were far from adequate. In the local general hospitals of the State, there were then 9,262 patient beds. The Hill-Burton objective called for 18,000 such beds.

The North Carolina goal for the general hospitals called for the addition of 8,803 new beds, and for the increase of the mental and tuberculosis beds to a prescribed number. Since that time, 4,332 local general hospital beds have been added or scheduled, and the program, still unfinished, calls for an additional 4,471 local general patient beds.

The 6-year program of construction since July 1, 1947, has cost an estimated \$68 million supplied dollars: \$24 million by the United States Government, \$14 million by the State of North Carolina, and \$29 million by the local hospital authorities. One hundred twenty-seven different projects have been approved by the Medical Care Commission since that date. They consist of 72 local general hospitals located in 60 of the 100

counties of the State; 24 nurses' homes to serve hospitals; 23 county health centers in which to house county health departments; and 8 State-owned hospitals for the mental, tuberculosis, and cerebral palsy patients.

Local Share Cost

The local share of the cost of the cooperative construction projects in North Carolina ranges from 16 $\frac{2}{3}$ percent in 13 of the poorest counties to 56 percent in 9 of the wealthiest counties.

The local share of the cost in the remaining 79 counties ranges from 16 $\frac{2}{3}$ percent to 56 percent, and 39 of the counties are required to supply 33 percent or less of the total cost of the hospital construction.

The hospital owners, as a rule, have agreed to provide hospital care without discrimination because of race, color, creed, or financial circumstances. Within a hospital, the beds for non-whites may be segregated, but there is no difference in the kind or quality of the facility provided for both races. In a few towns, separate hospitals are owned and operated by the whites and the Negroes. In such communities, the Commission has offered aid toward needed hospital construction to each race in proportion to its population.

The State Legislature, with limited Federal aid in a few instances, has financed a substantial increase in the number and quality of patient beds for mental, tuberculosis, orthopedic, and cerebral palsy hospitals. Moreover, it has financed, also without Federal aid, a 400-bed teaching hospital at the University. There is also now under construction at the University a 100-bed tuberculosis hospital and a slightly smaller psychiatric hospital.

Personnel Shortages

There is a shortage of medical, nursing and technical personnel for the staffing and operation of the new and existing hospitals. The program is greatest in the rural, agricultural communities which, economically, are the most disadvantaged. There has been some improvement in the maldistribution of medical personnel incidental to the staffing of the new hospitals. Moreover, many nurses who withdrew from practice to rear families have recently accepted service again in nearby hospitals.

The Medical Care Commission, in addition to constructing hospitals, administers a fund of \$337,500 annually to provide \$1.50 per day toward

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

the hospital care of indigents, other than dependent children, the aged, and the totally and permanently disabled, who are sponsored by the State Board of Public Welfare. The Duke endowment contributes \$1 per day toward the cost of the hospital care of indigent patients, and the Reynolds fund a somewhat smaller amount.

With Respect to Needs

Then, with respect to the needs in North Carolina, we may say that of the hospital construction program, barely 50 percent of the hospitals programmed under the Hill-Burton law have been built, contracted for or scheduled. That means that there remain something over 4,000 hospital beds yet to be built in the local general hospitals.

An inquiry among 100 hospitals indicates that the plans for the next 2 years, or the next biennium, will call for a continuation of the program on the present basis. We are hopeful that the student loan fund, administered by the Commission, and which is to finance personnel for service in rural communities in the completion of their training, can be carried out, and also that the indigent care program can be carried out as scheduled.

Statement¹ of

DR. C. RUFUS ROREM

Executive Director

Hospital Council of Philadelphia

Philadelphia, Pa.

* * * * *

The task of financing the costs of sickness which require hospitalization involves the medical profession, hospital trustees, patients and the general public.

Who is to pay the hospital bill? The public owns the hospitals with a national value of about \$8,500 million and a per capita value of more than \$50 per citizen in the average community. About one person in nine—17 million nationally—is admitted as a horizontal patient every year, on the average. Directly and indirectly the public finances the hospitals which incur expenses of about \$3,500 million annually, which means something more than \$22 annually per member of the population.

The individual citizen is concerned about his own hospital bill. The same point of view may be applied to the public's hospital bill for the services which it receives from institutions and medical practitioners. For the public must ultimately pay its own bills for the costs of hospitalized illness. The only question is: What segments of the public and by what methods? The remainder of this statement offers some answers.

The self-supporting members of the population must ultimately pay the full costs of service to themselves as well as to their financial dependents.

The financially dependent persons are of two broad categories:

(a) Those who are the personal responsibility of individual wage earners or family heads, such as children and other relatives; and (b) those who are the general responsibility of the entire self-supporting public, such as the unemployed, recipients of assistance, and other persons unable to pay hospital bills from personal resources.

The Insurance Method

I. *Insurance.* The rapidly growing Blue Cross and other insurance methods comprise the most practical method for placing the costs of hospitalized illness in the family budget along with other necessities. Each participant receives protection every year, and about one-ninth of them actually are admitted for bed care annually.

The insurance method removes the factor of financial uncertainty from the patients who receive care and from the hospitals in which it is provided. Insurance also increases the number of those in the population who are self-supporting with respect to hospital care and decreases the hospitals' need for additional income because of service to community dependents.

Patient Reimbursement

II. *Individual payments.* Reimbursement by patients for their own services at time of illness is satisfactory for persons able and willing to finance care on this basis, provided they meet the full expenses incurred by the hospitals. But this group is decreasing as a proportion to total hospital in-patient admissions. Moreover, the charges for hospital service to such patients contains very little "margin" to finance care for community dependents.

III. *Who shall pay for those who do not pay for themselves.* The insurance subscribers object

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

to extra assessments for service to those unwilling to join the programs. The individual patients consider charges for "free service" to others as adding insult to injury. This practice is a frequent target of critical articles in the public press.

Voluntary vs. Taxation

IV. The self-supporting population has two alternative methods of paying the bills for free and part-pay cases, namely:

A. *Voluntary contributions.* These may be made individually or by groups, such as Community Chests; annually or in lump sums, such as legacies or endowments for operating costs or for capital.

Voluntary contributions are "holding their own" in total amount, but decreasing as a proportion of total hospital support. There appears to be a tendency for new contributions to be designated for special functions such as professional education, research, and preventive programs rather than for care of free and part-pay in-patients.

B. *Taxation.* This method is used more widely than philanthropy in the provision of services in hospitals throughout the United States. It takes various forms such as:

1. Government operation of hospitals with salaried medical staffs, e. g., Federal hospitals for Army, Navy and the Veterans Administration; State hospitals for mental and tuberculosis cases; State, city and county general hospitals for the public, particularly those unable to pay the full costs of services.

2. Government payments to voluntary hospitals, such as: Federal reimbursement for veterans, handicapped, crippled children, and others. State and local government payments for public assistance beneficiaries and other approved free and part-pay cases; block-grants to voluntary hospitals for partial reimbursement for free and part-pay cases accepted for diagnosis and treatment.

The Responsibility for Hospital Costs

V. There has been considerable confusion within most communities as to how the self-supporting public should meet the costs of hospitalized illness for those who are unwilling or unable to pay their own bills. The situation is most acute in the older metropolitan areas where the tradition of voluntary philanthropy has outlived the public's willingness to make the necessary contributions, and where the official bodies have failed

to recognize that medical care in hospitals is an essential public service. Meanwhile, the voluntary hospital is often criticized for its difficulty in providing a service for which the public is unwilling to pay.

Any hospital could balance its budget if it limited its service to full-pay patients. The objective is to bring all patients into this category, by expansion of insurance protection and by public reimbursement at full-cost for services rendered on behalf of public beneficiaries. Generally speaking, the most equitable method of financing "free care" is by taxation, thus leaving voluntary gifts for the creative and progressive phases of service in hospitals such as prevention, education and research.

Expansion of Plant and Equipment

Expansion of plant and equipment is not always an unmixed blessing for the trustees, management and medical staff concerned with affairs of a hospital. As a general rule, the annual expenses of a hospital are about one-third the replacement value of the capital investment. Capacity to render a greater volume of service carries with it the responsibility for obtaining the income—from various sources—to finance the additional activity. There are, of course, situations in which a new capital expenditure will more than pay for itself, within a reasonable period of time, by avoiding waste in the use of personnel and facilities, or by stimulating new professional services which the public is willing and able to support financially.

The following standards are presented for the use of responsible individuals or groups concerned with hospital capital programs. They should be met before any substantial capital expansion program is undertaken. There may be occasions when statistical data cannot be offered as proof of the reasonableness of a hospital's proposal to expand its facilities. But proponents of such ventures should be prepared to furnish convincing evidence to a hospital's own trustees, to a potential contributor to the campaign, or to the civic representatives who are invited to assist in raising the necessary funds.

Clear Demonstration of Public Need

1. There should be clear demonstration of a public need for the new hospital service that would not otherwise be filled. This requires data concerning other facilities and services in all local

institutions and in neighboring communities. Many potential contributors may be expected to be more interested in the total community program than in the welfare and growth of a specific hospital.

2. There should be reasonable prospect of a high level of utilization of the present and expanded plant and equipment. This problem involves the use of the "beds" and the diagnostic and treatment equipment. Will there be sufficient available apparatus and staff to serve the increased number of patients? What will be the effect on the hospitals' volume of full pay, part free, and free services? Is the medical profession of the community sympathetic to the program under consideration?

3. The physical depreciation or the obsolescence of present facilities should clearly justify their being replaced. It is possible that they might be adapted for effective service by properly planned remodeling and modernization. Consideration should be given to possibilities of alternative use of existing plant, such as for employees' residences, doctors' offices, educational programs, out-patient services, and so forth.

A Realistic Program

4. The expansion program should take into account the plans of other hospitals in the general area. Occasions may arise where an institution will have an opportunity to supplement, rather than duplicate, existing facilities in the community, and to coordinate one hospital's services with that of another. This may require a degree of cooperation seldom found among the trustees and medical staff of hospitals eager to expand their usefulness in the community. But the concept of coordination should be seriously considered by all persons concerned with a capital program.

5. A realistic program should be presented for financing any additional current expenses entailed by the capital expenditure. In some cases, capital expansion, replacement or modernization may reduce current expenses or increase current income. But the income budget should allow for all possible changes in patients' fees, free work, government support, etc.

6. The capital program should conform to recognized trends in medical practice. The main purpose of a hospital is to provide good medical care in a manner which will achieve most effective

use of professional knowledge, skill, and facilities. Certain very important trends in medical practice are exerting a strong influence upon programs of service in hospitals and upon the necessary facilities to implement them.

Nature of Program

Physicians regularly prescribe early ambulation during periods of in-patient care. An institution planned for long periods of horizontal care in bed is not suitable for a program in which bed patients are "up and about" most of each day.

There is expanded use of scientific equipment for prevention and diagnosis. More tests and medical procedures occur. The hospital is a professional service center, not a hospice.

There is greater use of hospitals by physicians for care of private ambulatory cases, as well as the treatment of free and part-pay in-patients.

The services of physical medicine and occupational therapy in rehabilitation of the disabled are being recognized and applied in modern hospitals. This tends to reduce the necessary amount of bed care.

There is a tendency to serve all types of acutely ill cases in general hospitals, such as psychiatric, tuberculosis, orthopedic, obstetrical, pediatric, and so forth. This trend has occurred as a result of the desire of doctors and the public to improve medical standards and permit economy in use of professional personnel and equipment.

Priority Principles for Capital Needs

It appears that expansion of total bed facilities alone is the least pressing need of many communities at the present time. Nevertheless, some institutions face practical problems in maintaining a balance of existing bed accommodations with the number of patients recommended for admission by the attending medical staff. Moreover, some buildings are now unsuitable for continued use for hospitalizing bed patients.

In submitting the following priority principles for capital programs, it has been remembered that the essential feature of hospitalization is the quality of the care rendered and supervised by the medical staff. The level of the service provided in a hospital can rise no higher than the knowledge, skill, and devotion of the physicians in charge of prevention, diagnosis, treatment, and rehabilitation services.

Modern equipment and adequate layout are important and desirable, but their value is limited by the degree to which they raise the quality of medical care. With those ideas in mind, the following priorities are suggested for capital expenditure programs which involve community campaigns for contributions.

Priority Expenditures

The following types of capital expenditure programs should be given priority over more additions to existing bed accommodations. The sequence of listing is not intended to indicate absolute priority in every instance.

A. Renovation or remodeling which will (1) prolong the useful life of a building; (2) improve the quality of institutional or professional service; (3) release space for essential service.

B. Construction of new buildings, which will achieve more effective utilization of total plant and equipment, for example: (1) broader patient services to the general community; (2) additional diagnosis and treatment facilities for all patients; (3) improved layout to conserve time of professional and institutional personnel; (4) rehabilitation services for the disabled and chronically ill.

C. Any capital expenditure which will aid in the coordination of one hospital's service with that of another. Medical opinion is unanimous that a metropolitan hospital serving less than 150 bed patients cannot maintain adequate diagnostic and treatment staff and facilities for general medical and surgical care. It also holds that treatment of special types of illness (acute or chronic) requires active and continuous association with all branches of medical knowledge and skill.

Administrative judgment indicates that small specialized institutions must bear relatively higher overhead costs if they are to maintain the same professional standards as larger general service hospitals. Unless a hospital can be expanded to serve a bed capacity of 150 patients, with appropriate ambulatory services, it should be affiliated with one or more hospitals as a specialized department.

D. Construction of additional bed facilities, provided they will achieve a more effective balance among: (1) private, semiprivate and ward accommodations; (2) short-stay and long-stay cases; (3) service, education and research; (4) bed patients and ambulatory cases.

Statement¹ of

MR. MOODY MOORE

Director, Division of Hospitals

Arkansas State Board of Health

Little Rock, Ark.

In the memory of all of us a hospital was almost always a dead end street. Traffic was mostly one way. We knew very little about a hospital, and the nearest one was often miles away in a large city. When the family doctor sent someone there, things were mighty serious. The hospital was literally feared and even thoughts of it were shunned. There are parts of rural America even today where this state of mind still in part exists.

The State Health Department which I represent—and my immediate concern is with hospitals in Arkansas—challenges me every moment of my waking life to break down this awful concept of the past and interpret today's hospital to the people as it really exists—and beyond that, to make tomorrow's hospital even better than today's.

We know that the quality of hospital care and the wider distribution of hospital facilities, accomplished through the Hospital Construction Program and through our Hospital Licensure Program, have given better service to our people in Arkansas—but, are we doing enough?

Time for Critical Evaluation

We have too long rested upon our oars and drifted with the current of the river of "status quo."

I feel the time has come for a critical evaluation of hospital facilities which exist and the actual needs of the future. When I say actual needs, I mean those needs which are practical for a community and not needs which are theoretical and which look good on paper. There also needs to be a careful weighing of a community's needs versus the community's ability and willingness to support.

Prior to the passage of the Hill-Burton Bill, we in Arkansas had completed what we felt to be a rather exhaustive evaluation of existing hospital facilities and set forth what we felt to be an acceptable and functional determination of additional needs. Our current re-evaluation and re-determination program, though limited, has

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

provided much information to be used as a basis for the development of the State Plan for Hospital Construction, as is required annually by Public Law 725. This information has also changed our thinking in many ways. One such way was to introduce the concept of the small rural hospital or Community Clinic's place in the over-all picture.

The Small Rural Hospital

In the beginning those of us charged with the responsibility of planning and programing hospital construction under Public Law 725, questioned the advisability of constructing these small 10-20 bed facilities. We were so skeptical that in Arkansas we proposed only two such facilities and agreed that no others would be built until these two had proven successful. Such a policy was necessary to ward off the indiscriminate building that would be brought about by pressure from small communities momentarily floating on the "Magic Carpet" of civic pride and with no visible means of support. We have even gone so far as to discourage communities that were building with their own funds outside of the program.

Today I am convinced, as a result of our re-evaluation, that there is a very definite place in our American plan of integrated hospital service for the small rural hospital, provided such a facility can effectively serve its purpose of bringing needed medical service to the population, and where the community has the ability and willingness to support.

I would like to emphasize the fact that there are dangers in building small hospitals, and these must be considered in the administration of a hospital construction program in any State. The indiscriminate building of small hospitals in all rural areas is not sensible.

Hospital Facilities Attract Physicians

To substantiate my statement that there is a place for the small rural hospital, that it can operate successfully financially, and that good medical care can be rendered, I present the facts concerning the two units constructed in Arkansas:

No. 1: Cleveland County Hospital, Rison, Ark. Cleveland County, located in south-central Arkansas, is a lumber producing and agricultural area. Rison, the county seat is the only town of any size and is, by this factor and the factor of concentrated population, the logical location for a small rural hospital. There are no hospital beds

in this section of this hospital service area. The nearest facility is approximately 30 miles away and very often no beds are available even for emergencies.

Limited facilities so located will service parts of four counties and will serve as an emergency facility and feeder unit for the Regional Hospital in Pine Bluff.

A survey revealed that there were only two physicians in active practice and both were past 70 years of age. Before approval of the application for Federal aid, the community was assured of at least one additional young physician if hospital facilities were provided.

* * * * *

No. 2: Van Buren County Hospital, Clinton, Ark. Van Buren County is located in north-central Arkansas in a mountainous area. The Hospital Service Area in which Clinton, the county seat is located, includes most of three rather large counties. The area is long and narrow, with the area hospital center located geographically in its southern part. Persons from Clinton area must travel approximately 50 miles over mountain roads to inadequate hospital facilities in the Area Center. Clinton, the county seat, the location of this small rural hospital, serves the economic and social needs for mountain people within a radius of 25 miles.

There were three physicians in Van Buren County, all past 60 years of age. It was almost impossible for the people living in the outlying mountain area to receive medical attention even for emergencies. A majority of babies born in this area were born in the home or mountain cabins, and many without a doctor's service.

Here too, the services of a young physician were assured before this project was approved.

* * * * *

Staffing

Both units are satisfactorily staffed with round-the-clock registered nurses; have supervision by sufficient licensed practical nurses, and aides to render acceptable, though not ideal, nursing service. The present average ratio is 1.03 nursing personnel per patient. It is true that the R. N. supervisor must act also as operating and delivery room supervisor, administrator, housekeeper, dietitian, et cetera. But it is still possible to provide satisfactory service with the low volume of patients present in these small hospitals.

What of the possibilities of good and bad medical care in these small units? My answer is simply this: It is the physician's responsibility to deliver good medical care with whatever he has to work with; that is, assuming that he is a graduate of a good school, has had his internship, and has a strong, ethical, aggressive character. The consideration of these factors is the responsibility of the governing boards.

There is good and bad in every profession. So far our experience has been most gratifying. Just two weeks ago one of the young members of the medical profession, located in a small rural hospital, stated that the biggest problem he had was convincing the people that he was not trained or equipped to do everything.

Young Physicians and Surgeons

You ask: Are the young physicians and surgeons being attracted to the rural areas? My answer is yes, but I qualify this by saying that they are attracted on a limited scale, and then only where hospital facilities are or will be available. For example, a young, well trained, physician and surgeon has gone to Rison and is enjoying a tremendous practice. A young dentist has also located in Rison—the first in at least 20 years. A capable physician and surgeon, son of a local country doctor at Clinton, agreed to return to his home town only if a hospital was constructed. He has returned and is rendering a service to the people beyond imagination.

The modern doctor is not trained to render the outmoded saddlebag type of medical service. To further substantiate my answer is the fact that we average one and a half inquiries per month from young doctors seeking locations in rural areas with hospitals available. We also average one consultation per month with young doctors desiring to locate in rural areas, even at the expense of constructing their own facilities.

Therefore, we say—small rural hospitals have a place. But we warn of the hazard of indiscriminate building of such.

In addition to the factors already mentioned, we believe that we must educate the people of the community. In these two communities, as well as all others, we have made serious and continuing efforts to help our people feel and know that their new hospital belongs to them—that any hospital really belongs to the people it is built to serve—not to the State, not to the county seat, not to the city,

nor to the doctors, although it is the physician's workshop—but to the people. It is of, by, and for the people.

Statement¹ of MR. LEE S. LANPHER

**President
Cleveland Hospital Council
Cleveland, Ohio**

The membership of the Cleveland Hospital Council consists of most of the major hospitals in Cuyahoga County.

The Council also has associate membership that reaches as far as Youngstown, Canton and Ashtabula, Lorain and so forth. It is an effective organization that carries on a great many activities, including joint purchasing for the Community Fund Hospitals . . . collection services for bad debts . . . and sponsors a hospital finance corporation. . . .

* * * * *

I will be very glad to open myself for interrogation by any of those who want to do so. . . .

Problem of Hospital Beds

Commissioner RUSSEL V. LEE. Have you got enough hospital beds here?

Mr. LANPHER. I would think I would have to say no, although I think we are meeting the need fairly satisfactorily.

Commissioner LEE. How many beds per thousand people should there be?

Mr. LANPHER. The common figure, I believe, is around five.

Mr. GUY CLARK (Executive Secretary, Cleveland Hospital Council).

I would like to say that we are quite proud of the fact that we did make the first over-all survey of hospital needs of any large city in the country. That survey, partially conducted by the Council Mr. Lanpher spoke of, under the leadership of hospital administrators, did provide for 1,100 additional beds which will be completed within the next 2 years. Lack of funds is the only reason that we have not completed that prior to this time.

Our original estimate was for a little over \$9 million to meet that need but, as you know, hospital beds were costing about \$8,000 per bed at that

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

time and if we can get them for \$18,000 now we are doing very well. It makes a greater problem than we anticipated at the time it was made.

I would like to comment also on the fact that a lot of this grew out of a survey originally made at the request of Mayor Burton, now Supreme Court Justice, in 1940. That led up to all the various hospital activities, the building program which we have, part of which was the Chronic Hospital. That Chronic Hospital recommendation was included in that survey report of 1940, and following that a special committee was appointed to study that particular problem.

Hospital Associated With University

We believe, and I think I can speak with some degree of knowledge of the thing, being a member of the trustees, that we are going to have the finest hospital in the United States for the care of the chronically ill.

It will be associated with the Western Reserve University; in fact, they have already consummated a contract with them for medical service at that particular hospital. It will not be strictly a hospital which many of you think of in terms of a hospital for the sick, poor, or for the aged. It will be a strictly chronic hospital taking in pay patients, part pay patients as well as free. The activities of the Council are, as Mr. Lanpher told you, very broad.

The democratic procedure is such that we do have all these services and therefore an incorporated body. We are really two organizations.

Question of Self-Supporting Basis

Commissioner LEE. I would like to ask a couple more questions. Can a hospital be operated on a self-supporting or even a profit-making basis?

Mr. LANPHER. I would say that it can if all of its services are paid for at least on the basis of cost of providing them. There is nothing too mysterious about operating a hospital with the exception of getting sufficient money for every bit of service that you render which costs you money.

Commissioner LEE. Is any hospital in this area self-supporting without reference to philanthropic or public money?

Mr. LANPHER. Not to my knowledge.

Mr. CLARK. What was that question?

Commissioner LEE. I asked if any hospital in this area was self-supporting without referring to Federal or philanthropic or municipal funds?

Mr. CLARK. There are some that are certainly self-supporting even though the income from those agencies you referred to is not at per-capita cost. To that extent I think they are.

Commissioner LEE. What I am really trying to get at in considering this over-all hospital question—must we always assume that hospitals will have to have aid of some sort, either philanthropy or governmental funds?

Mr. CLARK. I think that is an unanswerable question. You have to put a lot of other conditions in there. The hospital that has all their patients paid for, from some source, if their rate structure is set up correctly, can operate just as well as any other business provided you do subsidize them or pay them for the service they render. Unless they have subsidy from some source, either income from endowment or payment from various agencies, they cannot any more than you can if your salary does not meet your living expenses.

Financing of Hospitals Is Basic

Commissioner LEE. It is a fundamental question the Commission has to have some advice on, how hospitals shall be financed? Shall they be regarded as a public charge or not?

Mr. CLARK. Of course they should to the extent the public assumes responsibility for the care of an individual. If a person is an indigent, it is up to the government or somebody else to take care of his hospital bills, although I recognize that is not generally accepted as a statement of truth by many governmental agencies, but it still remains a fact.

You can't keep a man in food, clothes, and shelter and all at once dump him on the front doorstep of a hospital and expect them to take care of him without some reimbursement. That is merely as simple as adding two and two and getting four.

I do not know whether the question is, where the question arises, and I do not know why it is such a difficult question for our government to realize that there is nothing unique about a hospital—that they should be able to get along without income any different from any one else.

Patient Well-Being First Priority

Mr. LANPHER. I would say this. Many times a hospital is confronted with this problem of whether he puts the welfare of the person or the financial obligations involved first. Of course, any real hospital is going to put first the physical well-being of the patient regardless of whether it

gets paid. In business, as I see it many times, you evaluate your credit risk. In a hospital you have no opportunity to do so, or at least a limited opportunity to do so because of the nature of the business and the kind of situation which calls for emergency care, and so forth. I think that is one of the big problems.

Insurance Coverage

Commissioner ELIZABETH S. MAGEE. May I ask you to what extent Hospital Service Association covers the actual cost of the patient's care?

Mr. LANPHER. It covers cost up to the point of capital expenditures. That is, it seeks to do so in all of the cases which are the responsibility of the Blue Cross Plan in this area.

I would not want to leave the impression that Cleveland is representative of the country because in the country at large there are varying situations that exist in regard to Blue Cross. Some of them do cover; some of them do not. But the services try to pay these costs.

Actual Blue Cross Coverage

Commissioner MAGEE. What proportion of patients in hospitals are covered by Blue Cross?

Mr. LANPHER. I believe the figure is between 65 and 70 percent.

Mr. CLARK. I think you should answer that in days rather than patients.

Commissioner MAGEE. What is it in terms of days?

Mr. CLARK. It is about 70 percent in terms of days.

Staff Appointments

Commissioner LEE. How many doctors in this town do not have any staff appointment to a hospital or have any hospital privileges? Is it a considerable number?

Mr. LANPHER. I do not know, but my impression is that it is not a considerable number. I would like to make this additional statement if I may take the time.

I think one of the big problems that confronts the hospitals in this community—and I think in most communities—is the availability of trained personnel to fill the needs of the institutions, and especially nurses.

There is a great shortage, there must be something done about it, and it is my impression that some agency must help the hospitals in this field of nurse education and possibly in other technical skills which are needed by hospitals, but especially

in the nursing field we find ourselves now training nurses not for hospital use particularly, but for the use of industry and government. Government is a big user of nurses. It is a great drain upon the trained people, trained nursing personnel of our hospitals when they are being drawn into government service, and so forth, and trained away from the hospitals. I think that this is one of the big problems.

Whether the Federal government should get into it is a matter of great controversy, and I rather suspect it should be on the state level and not on the national level.

Commissioner MAGEE. I was going to ask whether you cared to express an opinion as to what the solution of this is.

Mr. LANPHER. I think the solution is financial help for the training of these folks on a state level, I hope, and not on a national level.

Mr. CLARK. Madam Chairman, I would like to ask the Commission a question, if I may.

Commissioner MAGEE. What is your question?

Mr. CLARK. I would like to know how to explain just what the doctor had in mind when he said one of the questions they are trying to determine is whether a hospital . . . (must always have aid of some sort).

Hospital Financing Problem

Dr. LEE. The role of the hospital at the present time seems to be almost paramount. All medical services are being centered around the hospital, and the hospitals of the country generally seem to be in some financial difficulty, particularly when it comes to constructing any new ones. There seems to be no private capital that is interested in constructing a hospital for profit as it might other potentially profit-making business.

One of the questions we are looking into is how to solve that problem. Undoubtedly, in most parts of the country there is a need for more hospitals and how they should be financed, whether private capital could be interested if there was a possibility of even breaking even, whether it should be Federal money, whether it should be left to the States and the communities is one of the really fundamental problems in meeting the health needs of the country.

State Aid Basis

Mr. CLARK. I would like, therefore, to express a personal opinion rather than talk for the organization, based on many years of experience. I

think we must trend back toward help from the State. Mr. Lanpher spoke of the problem in regard to nurses. There is not only the problem of training graduate nurses but also a problem of training nurse personnel. When I say "nurse personnel" I mean practical nurses as well as graduate nurses. About 25 percent of the graduate nurses remain in hospital services. About the same percentage get married within a year or a year and a half or 2 years. The rest of them find their way to doctors' offices, public health service, industrial plants, and many other places.

The cost of graduate nurse training has now reached the point in many schools to as much as \$3,000 a year net loss to the hospital in the training of each nurse. The question is: Should the patient or the individual hospital sustain that loss providing their own workers to the extent of only 25 percent of them being retained?

I believe that is all wrong; that we have now reached the point where the training of a nurse and the amount of time consumed in her class-work, and so forth, is such that the hospitals in the near future must be helped in some respect in the training of the nurse. In other words, I do not think that the patient should be paying all that.

State Educational System

Commissioner LEE. Why could not that be part of the State educational system just like the State universities and agricultural colleges?

Mr. CLARK. I might say to you that has already been posed and we will probably do something about it at the legislature the next session, not only for the one item but for both of them. We do have in Cleveland now—we are quite proud of the fact that the board of education here in the past 2 years, through the sponsorship of our own organization, is now assuming a greater portion of the cost of the training of the practical nurse. We hope that can become statewide.

Practical vs. Trained Nurse

Commissioner LEE. While you are talking about nursing, we have been into that several times—what about the role of the practical compared with the trained nurse? What proportion of the nursing problem can be filled by the so-called practical nurse?

Mr. CLARK. I am not associated directly with the hospital and I am not a nurse so I would not want to answer that question directly except to

say that it is a matter to be proven. I think that as we have better trained practical nurses we will probably rely upon them for a great deal of bedside nursing under the supervision at all times of well-trained professional nurses. I think that is a must.

Commissioner LEE. You would not be prepared to give us a figure on that?

Mr. CLARK. I do not believe anyone is, because I do not think that we have adequate numbers of well-trained practical nurses up to this time in any community that I know of for anyone to give you a real sound answer to it. I think there will be places in the next few years that can give you that.

Statement¹ of

MR. GEORGE E. CARTMILL

**President, Detroit Area Hospital Council, Inc.
Detroit, Michigan**

Since 1940 there had been a phenomenal increase in prepaid hospitalization and medical care coverage. Michigan Hospital Service (Blue Cross) alone, which signed up its first subscriber March 17, 1939, had approximately 2,700,000 citizens of Michigan covered on June 30, 1952. (This exceeds 40 percent of the State population.)

Bed Need

From a bed need standpoint, the study disclosed a minimum additional need by 1950 of 935 general care beds and for the eventual replacement of 1,946 general care beds (currently located in sections of hospitals erected before the turn of the century) which do not meet the modern fire resistive construction codes or are located in structures not originally built for, but converted to, hospital use.

Immediately upon completion of the study, a nonprofit corporation was created (the Greater Detroit Hospital Fund), which embarked on a capital improvement campaign to raise \$19,720,000 for the purpose of assisting in the expansion of 10 existing hospitals and the construction of 4 new hospitals. On May 29, 1952, this corporation announced the completion of its objective. When construction is completed early next year, "about 2,000 additional patient beds and more hospital facilities for diagnosis, therapy, professional edu-

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

cation and research will be supplied by the money collected through the fund."

Approximately \$1,300,000 towards the cost of one of these new hospitals was provided for under Public Law 725 of the Seventy-ninth Congress (Hill-Burton Act). In addition to these 2,000 beds, approximately 500 additional general care beds have been or are being added to hospitals which did not participate in the United Fund raising activity. The total expenditure for all these expansion programs approximates \$60 million. It therefore appears that the Detroit metropolitan area is cognizant of the situation and is adequately coping with it. Not only has it met the need for additional beds, but it has also provided a large share of the replacement beds. To date, no beds for which replacement has been provided has been closed. Further, by early in 1953, the expansion program should be completed.

Present Adequacy of Medical Research

The hospitals in this area have not only a primary but a vital interest in medical research. It is continuously being carried on in all the larger hospitals in this area. Both governmental and nongovernmental funds are always available for this type of work. It would appear that many additional projects could be carried on if money in satisfactory amounts were available. However, this statement must be qualified. The amount of research that can be actually undertaken at any one time is controlled by the availability of trained personnel to carry on the work. Here an actual shortage exists. In fact the demand for trained personnel is greater than the supply. It is practically impossible to undertake new research until an existing project is completed. There are instances in which existing research programs are retarded by this shortage.

Current Shortage in Health Personnel

Current shortages of all types of hospital personnel are not unique to this area. Considerable hospital personnel needs specialized training or teaching. Hospitals are one of the major facilities for teaching programs in medical, nursing, and related fields. Locally, the majority of these programs are accomplished in nongovernmental-owned institutions. Shortage of nursing service personnel is the largest segment of the over-all hospital personnel problem.

There are two Federal, three State, four county, and six city-owned hospitals in this area. In all

but three of these institutions the teaching and training of nurses is practically nonexistent. On the basis of bed capacity, these institutions are above the average in size, but the percentage of local residents who are patients therein is low.

These nonteaching governmental institutions recruit nursing personnel from the voluntary hospital teaching institution. Many nursing personnel policies and practices are established by government without regard to local conditions. The public feels the impact of these only indirectly through taxes. However, when the public becomes a patient in a voluntary hospital he becomes vitally conscious of any policy or practice which increases the cost of his hospital bill.

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Prospects of Covering Costs

Voluntary nonprofit hospitals do not operate to make a profit—their purpose is to provide facilities to care for the sick. In performing that service, they seek only to recover actual costs. They have only two sources of income: (1) Charitable gifts and endowments; and (2) charges to patients.

The ever-increasing demands upon charitable people—you are well aware of the appeals that are made continuously . . . in the field of health and welfare . . . for other worthy causes . . . plus the effect of current income tax regulations—have tended more and more to curtail this source of income. Since gifts and earnings from endowments appear to be drying up, voluntary nonprofit hospitals will be forced to increase their charges to patients in order to avoid financial ruin.

Although these hospitals are not legally bound to accept patients for less than the cost of taking care of them, morally they cannot refuse care to the sick even when the cost is ruinous. The voluntary nonprofit hospitals are determined to continue to render the best possible care to their patients.

It would appear that it is manifestly unfair to expect the sick people who can afford to pay for their own care, directly or through prepaid hospitalization, to shoulder the burden of the difference between the cost of care furnished patients for which some unit of government has assumed legal responsibility and the amounts these units of government actually pay. Two million dollars is a conservative estimate of the annual deficit in this area alone.

Raising Expenditure Level to Meet Costs

If a unit of government legally assumes a liability for hospital care, it therefore seems logical that it is equally liable legally to raise its level of expenditures to a point where it meets the actual cost of the services rendered. If this were done, it would eliminate the necessity for hospitals to increase charges to patients who can afford to pay in order to cover a deficit, and the burden of caring for these patients would be shared by all the people rather than by those who are unfortunate enough to need the services of a hospital. It would also eliminate the danger that voluntary non-profit hospitals might have to reduce their standards of service or curtail their educational and research activities so vital to the health and welfare of the people in this area.

Charity cases (those patients who are financially unable to pay) are always accepted by voluntary nonprofit hospitals up to and frequently beyond available funds. The charity picture becomes somewhat confused though, when hospitals furnish care to patients for which some unit of government has assumed a legal responsibility. Government, through its taxing power, is in a position to provide the funds to pay for the services which they purchase. When government at State and county levels refuses to pay the actual cost of care, the difference between payments received and actual cost produces a loss to the hospitals—with “forced charity”, not true charity, as the end result.

Extent People Can Afford Adequate Medical Care

One of the early objectives of this Council was to develop a plan for providing care for low-income groups. This objective was accomplished in 1938, as the result of numerous studies when the hospitals incorporated the Michigan Society for Group Hospitalization as a nonprofit corporation. This was the predecessor to Michigan Hospital Service (Blue Cross). The plan simply stated is merely a contract by which a hospital through its authorized agent agrees for a stipulated prepayment to furnish hospital care if needed.

Our Council is very proud of the part it played in making this type of service available to the people in this area, as well as throughout the State of Michigan. It provides the voluntary means whereby hospital service on an organized

basis is readily available. At the present time, in excess of 50 percent of the population of this area is covered by a contract with hospitals.

Health Insurance Plans

Health insurance plans are also a part of the way by which the hospital segment of medical care is financed. Health insurance plans are contracts which indemnify persons for losses incurred or for money paid out as the result of illness. An additional 20 to 25 percent of the population is covered by commercial insurance plans.

With government at one level or another assuming responsibility for providing care for the medically indigent, those having specific illness, such as TB and mental, those in the Armed Forces, the merchant marines, et cetera, it would appear that the present needs are voluntarily well cared for.

In conclusion, it should be stated that the purpose and objectives of all voluntary nonprofit hospitals has been and always will be to provide the best possible care for all the people of the community. To accomplish this, they are continuously studying ever-changing conditions and needs of this community and meeting these changes as fast as finances will permit.

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Need for New Beds

Commissioner RUSSEL V. LEE. I would like to ask a question or two. How many bed-population do you think that we need, Mr. Cartmill?

Dr. CARTMILL. As a result of the regional hospital survey I mentioned upon which new beds in the Detroit area were based, it was determined by analysis of age population, income levels, and so forth, that 3.23 beds per thousand population were adequate here.

Commissioner LEE. Those are general beds?

Mr. CARTMILL. Yes, sir. It was an organization of general hospitals which undertook the survey.

Commissioner LEE. Do you think hospitals are over-utilized by insured individuals?

Mr. CARTMILL. We are not in a position to say that yet, sir, although we are investigating through several sources this over-utilization. I think there are preliminary studies that have been prepared already.

Commissioner LEE. What is your impression here?

Mr. CARTMILL. My impression here is they are not, but it may be because we have such a bed shortage there is no possibility of over-utilization. The demand is such that people are driven out as soon as possible.

Commissioner LEE. You are still short and your building program is not completed yet?

Mr. CARTMILL. Yes, the shortage is because it is not completed.

Commissioner LEE. Did you get the 19 million—

Chairman DR. BABCOCK. Twelve million from industry.

Commissioner LEE. Twelve million was from corporation donations, and not private philanthropy. Corporation took it out of allowable deductions for charitable purposes.

Mr. CARTMILL. Yes.

Commissioner LEE. That is quite a lot of money to raise in one community.

Mr. CARTMILL. We are proud of that.

Dr. BABCOCK. In two hospitals I can tell you that a survey has shown that 0.2 percent is the margin by which the noninsurance people stay longer than others. We thought it would be the other way.

The insured people stayed a lesser time in two of the big hospitals. They are currently interviewing and studying 10 of them, which can only be a spot check, but that was the question that has been raised and they do not stay as long.

They are partially diluted by so-called charity and staff cases which would stay longer, so maybe that is not a good figure.

Statement¹ of

MISS CORNELIA KNOWLES

Missouri Hospital Association

St. Louis, Mo.

The medical hospitals of Missouri feel that much progress has been made in meeting the hospital needs of the people of our State since the close of World War II.

Much credit is due the Federal grants-in-aid to hospitals under the Hill-Burton bill. This has not only aided many localities in providing hospital facilities which they seemed unable to finance themselves, but the impetus of the program spurred other communities to action.

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

Today there are 163 hospitals in Missouri totaling 37,948 beds. In 1951 these hospitals provided care for 433,975 patients. Others are under construction and in the planning stage.

There is no such thing as profit in hospital operation, whether the institution is operated by government, a nonprofit corporation, or individual. Any black ink at the end of the year is turned back to the community and to the patients in improved facilities and service.

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Lack of Uniform Program

We are concerned over the lack of a uniform program for providing hospital care for the indigent and medically indigent. Unfortunately, our State law leaves the financial responsibility for the indigent to the counties. Many counties do an excellent job in caring for these people. Too many counties, however, shirk this responsibility, particularly when they do not operate county hospitals. Through a survey to be sponsored by the Missouri Health Council we expect to find just where we stand. We believe that when the people of Missouri know the story they will act to correct this situation.

Another problem of deep concern to us is the need for an intelligent hospital licensing law. We are one of the few States without such legislation. We believe this is needed as a protection for the public, and it should be provided and financed largely by the State. . . .

Because of the rapid changes in medical science and the demand on our general hospital facilities for the care of acute patients, our hospitals are often criticized for their inability to care for the long term patients who need little more than nursing or custodial care. Nursing homes have increased in our State, as well as in others. Some of these provide excellent care for patients, but investigations have proven that others very definitely exploit the recipients of old-age assistance.

Poor Nursing Home Licensing Laws

The present licensing law governing nursing homes is so weak that many of the better homes operate without a license. A joint committee has been working with the Association of Nursing Homes to develop legislation which will be a protection for the public.

The chief difficulty in obtaining needed legislation and enforcing it is the limited budget of the

Division of Health. This limitation reflects itself throughout the Division's operations.

Personnel Shortages

Personnel shortages exist in almost every field. Perhaps it is more acute in the health field because of the manifold increase in the demand for health services. Hospital leaders, both locally and nationally, are constantly studying ways of using trained professional personnel to the best advantage. During the past two years doctors, nurses and hospitals have been working together through a joint committee known as the Missouri Conference for the improvement of patient care, in an effort to solve some of these problems.

HEALTH CENTERS

Statement¹ of
MR. GEORGE W. JOHNS
Secretary, American Federation of Labor
San Francisco, Calif.

* * * * *

The basic health need of this Nation, and the one which embraces all others, is this:

Some means of assuring that every worker and his dependents, rich or poor, shall have full access to the highest quality services of modern medical science, not only in time of emergency, but in the every-day preservation of good health.

The basic problem in relation to this need is an economic one. It lies in the increasing inability of ordinary working people to carry the burden of the mounting costs of illness and of preventive medicine. For the sad fact is that complete utilization of the resources of modern medicine is a luxury which only the well-to-do can afford, and that adequate medical care has been priced beyond the reach of the average working family.

It is not surprising that organized labor has given its attention to this problem, for the ranks of labor are made up of average working families who need and desire improved medical care, and who are hard-pressed to finance it from their own resources.

Over the course of the years, labor has made many efforts to provide means by which its members could have adequate medical care. None of

these efforts has been completely successful, although many have made a marked degree of progress. Probably the most concerted, large-scale effort has been the emergence in recent years of the union health and welfare plan.

Union Health and Welfare Plans

The health and welfare plan has had a particular development in the San Francisco labor movement. Under such plans, thousands of San Francisco workers and their families have a new degree of protection against the high costs of medical care. Unfortunately, there are still thousands of union members and others who do not have such protection, and unfortunately, the protection offered by such plans is limited and far from adequate even for those who have it. However, it can certainly be said that the union health and welfare plan represents a significant step forward.

To study the health and welfare plans within the San Francisco labor movement, the San Francisco Labor Council last spring authorized a survey to be conducted by a recognized medical consultant in an objective, scientific manner.

It might be easier to follow if we consider three questions. First, how many are involved in the health and welfare plans? Second, how much does it cost? Third, what do we get for the money?

First, as to how many people are involved. San Francisco is known as a union town, and that union membership is 90 percent AFL and is concentrated within the framework of the San Francisco Labor Council. The 187,000 union members represented by the Labor Council unions, together with their families, total well over a majority of the population of San Francisco.

Of the 141 unions affiliated with the Labor Council, 71, or half of the total, have some type of health and welfare plan. Eighty-eight thousand five hundred and thirty-five workers are covered under these plans, or 47 percent of the total. More than 60,000 are in plans providing for dependents' coverage of some kind. As new working agreements are completed, these figures are constantly increasing.

The next question is how much does it cost? The average monthly contribution per worker is over \$6, and the range is \$2.45 to \$17.33. The trend is for an ever higher amount.

Eighty-six percent of the members are in plans financed entirely by the employer. In May of this year, the total annual bill, including optional pay-

¹Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

ments for dependents and state unemployment and disability payments, was \$8,200,000 in San Francisco alone.

Indemnity Type Insurance

What do we get for this kind of money?

For the most part we get an insurance indemnity schedule which pays a portion of the medical bill. Seventy-six percent of members are under commercial insurance company plans, with the remainder divided about equally between nonprofit, fee-for-service plans and direct service plans. Dependents are not covered for the most part, and the benefits for dependents, even where covered, are extremely limited. There is a heavy emphasis on the surgical schedule. The first two doctors' visits are excluded in most instances. Preventive medicine and care of chronic illness are almost unknown. In effect these plans are basically surgical and hospital schedules.

The indemnity schedule is rarely adequate to cover the patient's bill. In general, only 35 percent of medical charges, 65 percent of surgical fees, and 85 percent of hospital charges are paid for workers. The proportions are far lower for dependents, although dependents' medical care constitutes about 80 percent of the average family's medical bill.

A major drawback is the unhappy tendency of the maximum indemnity schedules to become the minimum charges. This has resulted in an inflationary spiral which is a hardship on those workers who have a health and welfare plan, and doubly hard on the union members and others who do not have even such partial protection. We realize that the development of union health and welfare plans is not the only cause for the sharp rise in the costs of medical care in San Francisco, but we do feel that it is very definitely a contributing factor.

Problem of Benefits and Premium

The heterogeneous character of the various programs is also a drawback. There is divergency in the schedules of benefits; there is disagreement as to what benefits should be included; there is needless and wasteful duplication of administration. All these disadvantages may be traced to the lack of any unified, coordinated program.

Another drawback is the diversion of the premium dollar into other than direct medical benefits. Insurance company retention, brokers' com-

missions, excessive administrative costs, abuses of the fee schedule, and the like, drain off funds which could be used to supply medical benefits.

It seems obvious that the inflationary tendencies arising from these situations might well result in excessive premiums, emasculated benefits, or even abandonment of this type of business by commercial insurance companies.

These are all serious disadvantages of the present types of union health and welfare plan. But there are two more which are the most serious of all, and they are very closely related. The first is the absence of any guarantee of quality of medical care. The second is the lack of consumer representation, without which, we are convinced, quality cannot be maintained.

Nonprofit Program Proposed

Basically, what it all added up to was that our members were not getting the kind and degree of service they should be receiving for the amount of money that was being spent. To provide high quality medical care for AFL families, the San Francisco labor movement proposes to establish a nonprofit labor health center program.

This program is now in the planning stage. We propose to establish a series of modern health centers based on the highest principles of medical group practice, financed by negotiated welfare agreement funds. These centers would offer maximum, comprehensive health services of the highest possible qualitative and quantitative standards which would be available to American Federation of Labor members and their families, as an alternative to the various types of health programs presently available.

In these centers a modern team of doctors, concentrated around a nucleus of general practitioners, would be paid as a group on a per capita basis for the services they perform. These doctors might serve on a full-time or part-time basis in these labor-owned and constructed centers.

In addition, the Labor Council proposes to establish (1) a technical and professional counseling service which would be available to unions desiring assistance in setting up and operating their health plans; and (2) centralized administrative facilities which would be available on the same basis. These services could be utilized by unions not enrolled in the Labor Council health center program as well as by those participating in it.

Wide Participation

It is hoped that such a program can be carefully and scientifically planned for the utmost benefit to AFL families and to the entire community. Groups having a direct interest in such a program, such as the medical professions, medical schools, and employer associations, will be invited to participate on advisory committees with such functions as recommending policy and practice, defining and keeping watch over professional standards, auditing finances, and the like. Community groups which have a very real interest in the role of such a major new medical facility in the city will also be invited to serve on advisory committees.

The key to the entire program will be its emphasis on quality. Union members and their families are entitled to top quality medical care. We are not interested in establishing any "charity clinics" where union families will stand in line to receive county hospital-type treatment. This will be the union member's own program, and it is our intention that in it he will have available the finest facilities, the most modern equipment, and the most qualified personnel that can be obtained.

It is our hope that a continuing, voluntary, doctor-patient relationship will be established between the member and the general practitioner who will be the key man in the center.

To Fill Basic Need

As a guarantee that the union member, the ultimate consumer of the service, will have the high quality medicine he wants, this program will have consumer representation at all levels of policy and administration.

It is the contention of the San Francisco Labor Council that a program of this type goes a very long way toward filling the basic need outlined in our opening remarks: Some means of assuring that every man, woman, and child, rich or poor, shall have full access to the high quality services of modern medical science, not only in time of emergency, but in the every-day preservation of good health.

In a government of, by and for the people, it seems to me that support in the planning and initiating of such a consumer program might very properly come from our Federal government. In the case of the San Francisco Labor Council, it has been necessary to seek the assistance of a private foundation in carrying out the important

preliminary phases with the necessary scientific, technical care. However, the resources of such foundations are limited and usually not available. Surely there would be no source so fitting as the Federal government, with its long experience in the public health field and with its ultimate responsibility to the American consumer.

Fundamental Financial Problem

In a program such as we envisage a fundamental financial problem presents itself. The construction and future operation of the program can well be financed from funds presently being devoted to other types of programs. In the planning and organizational phases of such a consumer program, however, such funds are not available. To organize such a program on the best professional and scientific levels, help is necessary.

The financial and technical assistance of the Federal government to such consumer health programs (whether sponsored by labor or other consumer groups) would be one of the most genuinely significant contributions that could be made for the betterment of this Nation's health.

Federal aid to such programs would contribute in two ways.

In the first place, it would help to make available high quality medical services to a great mass of our country's population who do not now have access to such care. This in itself would be sufficient motive for the government's assistance.

In the second place, Federal aid to consumer programs would stimulate the entrance of the consumer into the picture. The preservation and improvement of the Nation's health is certainly a mutual problem, involving the patient as well as the doctor. For too long the patient himself has been the forgotten man, the bug under the microscope, examined and treated with scientific skill and coldness but disregarded as an individual.

Consumer's Voice

We would like to see the consumer, the patient himself, have some voice in the kind of program that is offered him and in the way it is run. We would like to see him recognized and respected as an important contributing factor in the progress of medical science. Such a concept is entirely in keeping with all the democratic principles embodied in our American way of life.

Ultimately, it would seem that a national health insurance program of the type advocated by the

American Federation of Labor may be found to be the best answer to the basic need. Undoubtedly such a program would meet the basic need on the broadest possible basis—that is, on a Nation-wide scale. Even if this eventuality should come to pass, however, consumer programs such as that envisioned by the San Francisco Labor Council will play a vital role in keeping the Nation healthy. It is our well-considered recommendation that the Federal government should lend its support to the planning and establishment of such consumer programs.

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Chairman SHEPARD. Thank you very much, Mr. Johns.

I would like to call the attention of the members of the Commission to the fact that Dr. Richard Weinerman is also in the room, the one who made the study. You may wish to direct questions either to Mr. Johns or to Dr. Weinerman.

Commissioner RUSSELL V. LEE. I would like to ask you one question, Mr. Johns. Of the \$8 million that the employers paid for health and hospital care, how much of it came out of the other end of the pipe, in terms of payments for doctors and hospital services?

Mr. JOHNS. Let me answer your question this way: We feel that what has happened to the premium dollar is that if you analyze the value of the actual medical services that comes out of that dollar, about 50 cents on the dollar is what we are getting. That is a conservative figure, and it may run below that. But we have played this very conservatively. In other words, 50 cents of that consumer dollar might be translated into actual medical services for our people.

Commissioner LEE. That is the only question I have.

Commissioner DEAN A. CLARK. May I ask Dr. Weinerman, Mr. Johns, why the quality of medical care has been criticized? Is it because of the unavailability of physicians, or improper training, or because he is rushed? Why is this quality poor?

Mr. JOHNS. What has happened—and we have detailed it in these reports—has been the cost of medical care largely through some of these inflationary situations that we ourselves have brought about by establishing guaranteed fee schedules. But removing from the doctor the responsibility of taking years to collect a bill has helped. We have paid cash on the line.

These things have resulted in very inflationary tendencies, with the result that costs have gone up. Today our people have been practically priced out of the market. Instead of being able to go in and get modern medical attention, which leads to our conclusion, it can only be provided where you have a team of doctors, a general practitioner or internist, who can wait directly on the people, but surrounded by the various specialists that they, too, should be entitled to have. It is only by moving in that direction that we feel we can get real modern medical care. Our people are not getting that. They can't afford it.

When you start telling a workman that his child needs orthodontistry and it is going to cost him \$800, \$1,000, or \$1,200 for that child to have it, that is clearly out of the picture. And that takes place in a number of situations.

Commissioner CLARK. I wonder if Dr. Weinerman would have anything more to say in that particular?

Dr. RICHARD E. WEINERMAN. Mr. Chairman, thank you for the chance to answer the question. In surveying the quality of medical care under these health and welfare plans in San Francisco, we did not actually attempt to make any evaluation of the quality of the individual physician's care.

I believe perhaps Dr. Clark's question was addressed toward that.

What we were interested in is what was the impact on the quality of care generally of the type of organization of the prepaid medical care plans. The point that the survey was making with respect to the commercial insurance company prepaid plans was that, administratively, they could do nothing to guarantee any level of quality in the service that the worker and his family receives. It was a job of the insurance company to pay the bills, or part of it, as the individual received his own physician's and hospital service. Yet the problem facing workers was not only to pay for medical care, but it was to make sure that they were getting the highest kind of care that their particular illness needed.

None of these plans, as I mentioned, could do anything toward it, and insofar as they gave rise to economic abuses there were some tendencies that the quality of care from time to time, as in the CPS problems, was being lowered.

What we were urging, therefore, was that a medical care organization seek not only to take

care of the economic problems of medicine, but to guarantee the standards of service on an organizational level, so that there were standards for participation of doctors and hospitals and standards for diagnostic and consultant work. All these things, professionally controlled, were built into the administration of the plan—the way it had not been done in commercial and nonprofit fee-for-service programs.

Commissioner ELIZABETH S. MAGEE. I would like to ask either Dr. Weinerman or Mr. Johns a question about your health centers. Is there to be a prepaid plan in connection with them for service?

Dr. WEINERMAN. The suggestion in the report which is being considered by the Labor Council is that the existing welfare funds that have been negotiated between management and labor, and are now actually operating as funds, be used for the financing of prepaid service through group practice health centers.

Statement¹ of

DR. MORRIS BRAND

Medical Director

The Sidney Hillman Health Center

New York City, N. Y.

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Labor has been aware of the Nation's unmet health needs for a long time. Proof of this is found in the early history of the country when employers found it necessary to assure physicians' services to the workers in mining, lumber and railroad camps far removed from towns.

Workers learned that they could acquire some protection against the hazards of sickness and accident disability and could cover their burial costs by organizing fraternal and other quasi-social types of organizations. Also under the pressure of trying conditions, workers found that in order to improve their standard of living it was necessary to organize trade unions.

Gains Extended

The targets at first were the shorter work day and week and better salaries. In time their activities resulted in the promulgation of safety laws and workmen's compensation benefits; eradication

of child-labor; development of labor and management grievance machinery; passage of unemployment and disability insurance; paid holidays, vacation and sick leave; hospital insurance coverage and retirement plans. With the gains in job and other social securities, greater emphasis is now being placed on acquiring health and medical care benefits—progressing in many instances from the stage of insuring only the workers to that of including the dependents.

* * * * *

Sickness a Luxury

As things are today, and in view of the frightening predictions of a still mounting cost of living, sickness is a luxury, financially beyond the means of the workers. It is therefore necessary to overcome the economic barriers to the kind of health services workers require for themselves and their families.

The medical profession and commercial insurance companies state that voluntary insurance programs are removing the financial barrier. However, the Report on Health Insurance Plans in the United States, presented by the Honorable Herbert H. Lehman to the Eighty-second Congress, indicates that with few exceptions these programs are woefully lacking.

Fifty percent of the population does not have any form of medical care insurance, and only 3 percent has comprehensive medical coverage; 15 percent has hospital insurance coverage only; 21 percent has both hospital and surgical insurance; and 11 percent has hospital, surgical and limited medical coverage.

And are the voluntary insurance benefits removing the financial barrier for even this 50 percent? No, of course not. It has been shown in several studies that the "protected patients" are required to pay an average of 50 percent or more of the medical bills incurred for the so-called protected conditions. It is self-evident, therefore, that the barrier is hardly bridged.

The Bureau of Labor Statistics stated several weeks ago that the cost of hospital care index rose to 260.7. It is easy to foresee the near future when hospitalization for the low and middle income classes will be completely out of their reach, and it is doubtful whether the service type of hospitalization insurance will be able to continue

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

without either markedly increasing the premiums or curtailing the service benefits provided or substituting partial indemnifications for service benefits.

Since hospitalization of sick people will continue to be necessary and the costs will be beyond the means of most, the only feasible remedy would be to provide a national hospitalization insurance program where everyone will pay in accordance with his means and all will be assured of adequate hospital care when deemed necessary by their physicians.

* * * * *

Special Insurance Benefits

In the absence of a national medical care insurance program, the Congress of Industrial Organizations has made the acquisition of social insurance, including medical care benefits, a definite part of collective bargaining. These are no longer "fringe" benefits.

Insurance plans against the hazards of disability, unemployment, compensation and medical care for illness and injury incurred in the course of employment, retirement benefits, hospitalization and medical care programs are important to the people's improved standard of living, as are better housing, good nutrition, better hours and working conditions and wages. It is no surprise, therefore, to learn that in 1950 better than seven and one-half million organized workers were the recipients of social insurance benefits acquired as a result of collective bargaining.

* * * * *

Preventive and Curative Services

A medical care program that would be of full value should include medical services by general physicians and specialists in the office, the home and hospital. It should include all the preventive medical care, including periodic health inventories, as well as curative and diagnostic care; refractions and glasses; hospitalization; rehabilitation services; medication and other sick room supplies; dental care; public health nursing services in the home; laboratory and radiographic services; ambulance services; surgical appliances and other auxiliary benefits.

The organization and the development of a national comprehensive medical care insurance program which incorporates within its principles and

functions the above preventive and curative health services will mean a decrease in the number of persons who become ill and disabled; a decrease in the length of illness and complications; the prolongation of lives; a decrease in human suffering.

Furthermore, it will reduce wasted manpower and the loss of wages, and will eliminate borrowing to meet the unpredictable and high costs of medical care. It is possible that the savings from the above applied against the medical insurance costs would more than offset the high costs for high quality medical care.

The CIO Council believes that the spouse and children should also be insured, because it has been shown that on the average the spouse and children receive 75 percent of the total medical care needed by a family. It has been shown in comprehensive medical insurance programs that about 80 percent of the medical care provided to the family is rendered in the doctor's offices. Again it becomes obvious that medical service must be available for the day-to-day requirements and not for catastrophic illness alone.

Quality Safeguards

The comprehensive program should be available without limitations as to number of services, age, sex, color of the eligibles, and other artificial barriers. Furthermore, the programs must assure the people of high quality of service by physicians qualified in accordance with the highest professional standards. Medical group practice must be permitted to continue to point the way to the most efficient use of the professional knowledge, skills, technical and other personnel, and equipment. Reasonable safeguards should be established to prevent abuse either by patients or doctors.

At this point the Council wishes to state that labor has no desire to cause regimentation or harassment of the medical profession; it does not wish state medicine. Labor sees the unmet needs of people as well as the knowledge and skills of the medical profession which are not fully utilized and seeks to bring them together. To have this tremendous potential of the best medical knowledge in the world and not to make them available to our people is, on the one hand, sheer waste of the physicians' training, experience, and all the medical equipment; and, on the other, waste of human lives and resources.

Labor fully understands that physicians' standards of living must be maintained so that they can provide their services in a proper frame of mind, maintain their dignity and responsibility in the community and enjoy the social securities available to the rest of the population. Labor knows that the happy physician will better serve the sick and disabled.

ACWA-CIO Resolutions

In order to promulgate a national medical care program, shortages of physicians, dentists, nurses, physical therapists and rehabilitationists, health educators, technicians and others must be relieved. The following resolutions adopted by the ACWA-CIO set forth several of the needs which must be remedied—whether a national health insurance program is instituted now or later:

1. Aid to professional schools for training of health personnel.
2. Aid in building hospitals and group medical practice clinics.
3. Extension and expansion of State and public health services.
4. Aid to maternal and child health services and expansion of programs for the physically handicapped.
5. Development of mental health programs to improve mental hospitals and training of personnel.
6. Aid in understanding and prevention of chronic diseases and,
7. Extension of rehabilitation services.

Trend Toward Positive Action

In the absence of legislation or legislative action, labor has taken steps to achieve better health protection for its members. Unions have organized medical care programs, often limited in scope, by available funds with the thought that their action was one of expediency and that in time their full goals would be reached. Examples are the Sidney Hillman Health Centers of New York and Philadelphia, established by the Amalgamated Clothing Workers of the respective cities, the International Ladies Garment Workers, and the Hotel Workers Health Centers in New York City.

The trend toward positive action in this field is accelerating. The New York Joint Board of the Laundry Workers, an affiliate of the ACWA, has

purchased land and is planning a medical center for its membership. In San Francisco, the Labor Council of the American Federation of Labor is surveying the present medical programs of its union locals in order to determine the necessary features to be included in a comprehensive labor health program, possibly for the entire membership of the Council.

The Amalgamated Clothing Workers' unions in Rochester, Cleveland, and Chicago, have also taken steps to determine ways of organizing medical services for their members. All these and many others in existence—and to be conceived—are manifestations of labor's restiveness with the lack of a solution to its unmet health needs.

Workers found that they could not and should not wait for the medical profession to find a solution to the problem. Medical care is too urgently needed. Excellently trained men and modern facilities are available. In many instances, with the aid of employer-contributions made possible through collective bargaining, medical care programs were established. In others, unions obtained the necessary funds from its own membership. Organized labor will certainly expand its efforts to relieve the problems of medical care and medical costs which face its members as long as these problems exist.

Statistics and Examples

As an example of what has been done for a group of close to 40,000 members of the New York Joint Board of the ACWA who received medical service at the Sidney Hillman Health Center of New York in 11½ months, a few statistics are cited:

- 10,090 members used the services.
- 29,703 general physicians' services.
- 30,253 specialists' services.
- 4,501 radiographic examinations.
- 44,487 diagnostic laboratory procedures.
- 10,888 physical and rehabilitative treatments.
- 2,200 other ancillary therapeutic services.
- 25,751 prescriptions dispensed at a nominal cost in the Center.

The above physicians' services were provided by general physicians in 9,676 hours and by specialists in 7,789 hours.

As an integral part of the service, reports of diagnostic and X-ray procedures and consultations are mailed to the local physicians of the union members.

The services which are provided in the Center, located in the heart of New York's men's and boys' clothing industry include:

Allergy	Orthopedics
Cardiology	Otolaryngology
Chest	Peripheral-Vascular
Clinical Laboratory	Physical Medicine and
Dermatology	Rehabilitation
Diabetes	Proctology
Electrocardiography	Psychiatry (diagnosis
Gastroenterology	only)
General Medicine	Radiology—Diagnostic,
General Surgery	superficial therapy,
Gynecology	deep therapy
Internal Medicine	Social Hygiene
Neurology	Urology
Ophthalmology	

The medical staff of 80, 26 general physicians and 54 specialists, has been selected in accordance with the professional standards adopted by a Medical Advisory Council.

The above statistics, impressive as they are, become more so when considered in terms of the individuals receiving the services. Statistics cannot convey the members' feeling of relief and assurance that medical services are dispensed in accordance with need rather than ability to pay and that they are free to discuss their medical and socio-economic problems with their physicians and the Center's personnel.

The figures do not reveal the number of instances in which complete examinations revealed unsuspected medical conditions, thus making possible early treatments, which avoided serious long drawnout illnesses, complications and disabilities. Numbers also cannot mirror the joy and relief of many members concerned about symptoms, who were assured that their ailments were temporary and not of a serious nature.

Value of Contribution

The value of the Center's contribution to the union members and the community is expressed in the following editorial in the August 2 issue of the New York Times:

An impressive report on the work of the Sidney Hillman Health Center of New York in the year since it was founded is issued by the New York Joint Board of the Amalgamated Clothing Workers, CIO. The report entitled "Health Security by Union Action," describes how forty thousand workers in the men's clothing industry in New York acted to meet their health problems when mounting costs of medical care moved beyond their means.

Made possible initially by the joint action of the union and the New York Clothing Manufacturers Exchange, the Center's operating budget is met by an annual fee of \$10 paid by members of the locals who have joined. For this they receive a comprehensive medical inventory, as well as day-to-day medical service. The service has already been extended to the wives of members, and it is hoped that the entire family unit may soon be included.

The Health Center is probably the most fitting memorial that could have been devised to honor the memory of the late Sidney Hillman, founder-president of the union, who died in 1946. It was conceived by those who pioneered with him to raise the living standards of workers in the men's clothing field and to advance the many other constructive social objectives of this truly progressive labor group.

These medical centers in New York and Philadelphia have filled a lack in the social insurance programs the ACWA established many years ago. The latter program, completely financed by the employers, is administered by the union through its own insurance firm, the Amalgamated Life Insurance Co. The members are entitled to hospitalization and surgical indemnification, life insurance, retirement benefits, sickness disability, and maternity leave benefits.

Basic Problems Community-wide

Acknowledging the improved health status as a result of limited programs and realizing the inestimable value of a complete program of medical care security, Mr. Louis Hollander, president of the New York State CIO Council and vice president of the ACWA, has stated:

But these splendid health centers, too, we can regard only as stop-gap measures. They do not fully solve the problems of adequate medical care even for the members of these organizations which have been able to set them up. More importantly, they do not solve the problem of medical care and medical costs for the community. They contribute to community well-being; they supplement and relieve the community's facilities so that they can better serve the rest of the public; they do not and cannot in themselves provide an answer to the basic problem which the community must solve.

Labor takes no narrow view of the problem. Organized labor is an integral part of the community and therefore considers community well-being as its concern. We shall continue to make what progress we can in the field of health on behalf of our members and their families, but we will not consider the problem solved until all phases of it have been solved, and for all members of the community.

It is the position of the CIO, together with a great many other public spirited groups, that this is a job which the people of our country can accomplish only through their national government, as the only organized agency that can administer and fulfill such a vast and intricate program. A comprehensive national health program—

with national health insurance as its basic plant—would round out the social security structure the Nation has built up over the years and which has contributed so much to our social and economic progress.

Statement¹ of

MR. ROBERT B. GLATTER

**International Ladies Garment Workers Union
Dallas, Tex.**

Men and women who gather to consider and promulgate the health needs of a Nation surely have some positive reaction to the stupid human debacle of the past twenty years: depression of the Nation's economy, total war against fascistic ideologies, reconstruction of war ravaged countries and peoples, and all with a continuing shadow of very ominous portent still hovering on the eastern horizon.

Or, should they prefer the ivory tower, the luxury of isolationism, they need but glance at the churlish activities presently occupying our Nation on the so-called "home front": production for defense, military preparations, military conscription. Who among them would argue to refute or refuse complete health and medical requirements for our soldiers, or for our workers when loss of man-hours of production is of vital concern to mutual defense?

An honest health program for our citizens based upon survival alone is still worth the effort; but somewhere, some time, we should begin to utilize man's reasoning power and human ingenuity to contribute for the betterment of all men and not merely for the destruction of some other man—some enemy.

A Prepaid Basis for Health

A prepaid medical program, properly supervised and properly endowed, is needed right now—preferably for the improvement of all mankind, essentially for his survival. We shall not be able to rid ourselves of the obligation, nor of the responsibility. Certainly we shall not be able to rid ourselves with a little liver pill of the effect of the atom bomb on our way of life.

Should this appear to sound like "welfare-state or socialized medicine" talk, economic fears should not overshadow intelligence. The terms, or phrases, welfare-state and socialized medicine have become psychosomatic trigger words to the minds of the smug and the complacent. Words

are created by human beings, and, necessarily, carry human ailments. Psychiatrically speaking—physician, heal thyself and then examine the patient.

It is as the patient that we appear before this Commission; the term "working men and women" constitutes the one largest majority, 61 million with common interests in this Nation of 140 million of the people, for the people, and by the people. The large portion of these men and women who constitute organized labor do not flatly advocate "socialized medicine," because we recognize the large political football such a program would inflate.

We need complete health service on a prepaid basis drawn from the real economy and wealth of this Nation—the raw resources, the skills and productivity of its workers, the abilities of its management, the creativeness of its human minds. Within this economy is the ability to put aside a small portion of the profits of this combined effort and wealth to provide a constructive and complete health program for all of its people.

This patient has tried to help himself with self remedies. Since before 1913, and to the present day, the International Ladies' Garment Workers' Union has contributed leadership through its health service to its members. Starting at the very beginning, in the days of sweatshops and tenements—where unsanitary working and living conditions made for drastic disease ratio among its membership, when strikes were called due to these filthy working conditions, and were settled when the boss went so far as to provide toilet-tissue for his workers—organized garment workers have helped themselves. Relief committees were elected, or appointed, or volunteered to aid and provide for the unfortunate when the very word unfortunate was strictly relative.

The First Union Health Center

New York City's Union Health Center, the ILGWU's pioneer, opened its doors in 1913 with a single physician and exceedingly limited equipment in two tiny rooms. Four years later it was incorporated. A New York State license was granted in 1930. In 1935 the Center moved into its present skyscraper building, occupying 13,000 square feet. Following wide gains in health and welfare benefits through collective bargaining, a comprehensive expansion program was initiated. This was completed in the closing months of 1948.

¹ Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

Today the Center occupies five upper floors and large main floor space with a total area of more than 100,000 square feet; the Center holds 55 modern examining rooms, including suites for multiple clinics in such services as Eye, Chest, Heart, and Urology. The center also includes a physical-therapy department containing 22 cubicles for electrotherapy and hydrotherapy, an X-ray department equal to that of a good sized hospital, a completely equipped laboratory, a drugstore capable of dispensing more than 600 prescriptions a day, and a nutrition suite, containing classrooms, offices and a demonstration kitchen. In addition, it houses offices for staffs in accounting, statistics, social services, a medical record librarian, and the large file room for hundreds of thousands of medical records and patients' charts.

The single doctor of 1913 equipped with what he could carry in his little black bag has grown to the following: a staff of 175 physicians, 33 nurses, 5 pharmacists, 27 technicians, and 150 clerical workers.

Today the equipment and services make the Union Health Center a completely rounded institution using all the advancements of medical research in diagnosis and ambulatory treatment. It is credited with being the largest institution of its kind in the world.

It sounds impressive, particularly if we have a tendency for large institutions. However, it was primarily due to the wage hike in 1942 which fully brought about the health services needed as early as 1922. Wages were hiked, frozen, and could not be increased. So-called fringe benefits based on small percentages of total payrolls became the order of the day. . . .

Here in Dallas, Tex., our ILGWU Garment Industry Health Center is in precisely the same size and condition as that small health center in New York City almost 40 years ago. The need for a Health Center capable of providing all health services for over 3,000 garment workers and their families in this area is present and could be provided through collective bargaining negotiations, now, within the framework of the garment industry in Dallas.

Nation-wide Health Centers

Across the entire Nation, in 14 major cities and smaller communities, health centers are operated by the ILGWU in the best manner possible in view of the circumstances of organization of the indus-

try and the size of the membership of the local organization.

A great variety in the size of locals and conditions in the towns in which shops are located has led to the development of different approaches to the problems of providing health care for the ILGWU members in the Southwest District, of which Meyer Perlstein, is Regional Director. This has real value since it permits study of flexible and effective plans. Any rigid approach in this vast area naturally would be completely unwise.

Plans vary from large health centers with extensive staffs of specialists through smaller centers with a general practitioner and one or two specialists, to arrangements for special sessions in a doctor's office when the group is small. Where it has not been possible to develop direct medical services, insurance plans have been instituted. More and more, the insurance plans are being designed to provide medical care for nonhospitalized illnesses so as to prevent neglect of conditions which may lead to catastrophe.

In all cases where funds have been set up for direct medical service to the members in this district, they are under the management of a joint commission composed of representatives of the union and of management, with an impartial member of the community as chairman.

Members pay nothing for the services under the various medical plans when the services are rendered at the medical center or the doctors' offices. Great emphasis is laid in all cases on the importance of periodic physical examination and on the principles of preventive medicine and health education.

First Objective—Medical Care

Medical care is naturally the first objective. Illness is a calamity to any person. But illness falls with terrible weight upon the worker whose savings are slim and whose resources are usually bounded by the weekly pay envelope. The breadwinner is always under pressure to get back on the job too soon after sickness, because the wages are desperately needed for food and rent.

First of the health centers in the Southwestern Region, the Dallas institution, proved that it was practical to cover a group of shops employing between 700 and 900 people. A plan was developed for eye care, general medical service, and gynecology inasmuch as 98 percent of our membership are women. About 3,000 patient visits a year are

being recorded. In addition, the nurse makes constant visits into the shops at noon hours to do health education and preventive medicine work with individuals.

The Dallas Center consists of a reception room and two examination rooms, with the facilities of a well equipped doctor's office. Laboratory tests are sent out. X-ray requirements are purchased by the patient on the outside. Some physiotherapy is done on the premises and arrangements have been made with a neighboring pharmacy to provide for reduced rates on prescriptions.

This obviously is health service of a very limited nature; the need is for complete diagnostic, ambulatory, and clinical treatment in all specialties of medicine. It has been the experience of ILGWU health centers that the patients, due to limited income and average living costs, are unable to provide for the high costs of specialized laboratory work, treatments, and care. Even with the limitations imposed upon this small health center, it is found that the patients are appreciative of the attention to their individual sensibilities and problems in providing diagnostic service in amicable and pleasant surroundings.

The need, then, is for complete health service on a fully prepaid basis with consideration given to the individual on the premise that the industry, to which health and well being are expended, in return provides care for that health.

The limited achievement of our organization in the field of health and welfare plans, democratically conducted and guided by local committees, has created a body of successful experience to which many of our sister labor organizations point as a standard. We take some pride in the historic fact that the ILGWU's pioneering in this field opened a road which has been followed by many other trade unions and socially minded groups.

Statement ¹ of

ISIDOR MELAMED

The Central Labor Union

American Federation of Labor

Philadelphia, Pa.

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Labor's Medical Centers

In Philadelphia, the ILGWU established a health center of its own to take care of the acute

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

and chronic illnesses of its members. It also provided a preventive service at the center.

This was later followed by the establishing of the two more medical centers in our city; one for the workers in the men's clothing industry and another, the A. F. of L. Medical Center, for all of the local unions of the American Federation of Labor in this area.

The first two of these centers serve their union members only. The last one is open to any local union in our city that has a health and welfare plan within their industry.

The two medical centers with which I have the honor to be connected serve a population of over 30,000 people, all members of organized labor. These centers render complete ambulatory medical services to the members of their affiliated unions, without any cost whatsoever.

All expenditures for the operation of these medical centers are paid out of funds of the health and welfare agreements between industry and labor.

The medical staff in these consist of, in addition to general medical doctors, all specialty fields of medicine that are needed to cover a complete service to the ambulatory patient. The centers are also staffed with the appropriate technical and lay personnel.

The services at these medical centers are unlimited and the only guide as to the amount of medical attention rendered to the patient is determined by the physician in charge of the patient's case.

The medical centers operate on a strict appointment system in arranging for service.

Every effort is being made in the center to give the service with a minimal loss of time to the patient, most of the work being done after working hours.

Health Center's Progress

The ILGWU Health Center has now been in existence for over 9 years. The members of this union represent workers of the ladies' garments industry in Philadelphia, 85 percent of whom are women.

During the entire period of its existence, on an average, about 26 percent of its membership receive services during any given year.

The A. F. of L. Medical Center has been in existence over a year and a half. It represents 11 different local unions of the American Federation of Labor in Philadelphia, over 80 percent of whose membership is male.

During the first year, the attendance by membership of various unions went from about 22 percent for one local union for a 7-month period to 38 percent for a full year for another local.

With the exception of some occasional discussions at the meetings of our affiliated unions, at no time was there a concentrated educational program that would attempt to encourage the members of these unions to seek service in the health center; and at no time whatsoever was there ever an attempt at all to sell the medical service to the members for the purpose of bringing its attendance up to show a large membership participation in these centers, just to build up a case on its behalf.

It is only by the service we rendered our people that the importance of the medical centers became known and accepted by our members.

I am fairly certain that had we had an educational program and especially a continuing one, the volume of attendance would be by far greater than it is now.

Survey Shows Importance of Cost

In order to find out how the attendance of our members to the center compared with the number of our people that would be seeking medical service through other facilities, private or public, if they did not have the medical center, we made a survey among those of our members who are patients at the medical center—this survey was made on three different occasions.

Our information discloses that no more than about 8 percent of our people would seek outside medical service; and then, only when they in their own mind would be satisfied that their sicknesses have been with them long enough to warrant their seeking medical advice.

The overwhelming majority of the answers to why they would not see or would not have seen a doctor earlier were based on the fear of high cost that it would have involved them in seeking such services. The next answer was the fear of the loss of time from work, should their family physician have to follow up with some studies from them, or seek a specialist's advice when necessary.

Another reason for the small number of the memberships' not looking for medical services earlier—in the absence of the available medical facilities of the health center—is the fear of referrals to specialists when needed on the part of the patient's family physician, because of the cost of such specialist services, or for that matter, the

failure of the patients themselves in keeping an appointment with a specialist even after the doctor advised them of the need for it. This holds true for men and women alike.

There are, of course, a number of other reasons given, sometimes in jest, sometime very seriously, such as, "I do not want to find out what is wrong with me," or "When my time comes I'll go anyway."

However, on many an occasion we have seen these people coming into the medical center soon enough when an illness gets hold of them; probably only because of the availability of our medical center.

Number of Visits

A further illustration of the validity of this survey—even though not a scientific one—may be shown by comparing the number of visits made by the members who receive services at the medical centers without cost, and the families of these members, who are eligible to receive services at the medical center in the technical departments such as laboratory, X-ray-BMR, et cetera. Families of these members, however, must pay for these services, though the payments are at cost.

The statistics for a 3-year period for 1949, 1950, and 1951 shows the following comparison between these two groups.

ILGWU

Year	Member patients	Visits	Family patients	Visits
1949-----	3, 946	39, 537	68	204
1950-----	4, 192	40, 996	72	243
1951-----	5, 106	41, 500	51	173

In the A. F. of L. Medical Center during the first year of its operation, with an average population of about 6,000 members, 1,713 members made 16,338 visits, and family members using the same facilities—for which they have to pay—only made about 92 visits during the same period—44 individuals attending.

To continue this illustration, one of the affiliated unions of the A. F. of L. Medical Center does cover its families. It is a very small unit, with a little over 400 members, and together with their families comprise a population of less than 1,500 individuals. During the last year, this group made 4,216

visits, of which more than two-thirds were made by their family members. Compare these figures for the same period with those of one of our local unions representing a membership of about 1,600. This group made during the same time 4,764 visits by members only. Still another union during an 8-month period, with a population of 3,200 members, made 5,500 visits, also by members only.

Usefulness of Medical Services

The statistics I have cited above should unquestionably prove that medical services, when made accessible to people of the earning capacity of our members and, without fear of any financial involvements, would be used by them at any time they were needed, or whenever illness may be harbored; and, should further prove that this whole problem is definitely and primarily an economic one.

There are many other statistics pertaining to our medical center. I will cite only one. The average number of visits per patient in any given year runs from 8.4 to 10, depending upon the membership group, sex, age, and so forth.

This Commission is welcome to the use of any of our records or facilities that it feels would be useful to it. These charts will show that by now there are hundreds of our people, to whom we added years of life, and many of whom are still on God's earth only because they have come into the center, very often on a complaint that had nothing to do whatsoever with their acute illness, and were caught in time to be given proper medical care that was actually responsible for saving their lives. They are now useful citizens of our community, working in their respective trades, just like you and me. Others were not so fortunate.

Another question that is often asked of us is about the so-called cranks utilizing the facilities of the center, doctors' time, and everybody else's time, uselessly.

Time will not permit me to recite how insignificant this whole problem is, and how little time, of the total picture is consumed by the so-called cranks. The mere examination of our statistics of attendance belies this contention. But I would welcome a competent committee to make a complete investigation on this picture, and I assure you that it must come up with the answer that the so-called crank population of our people attending the center can be counted in less than single percentage terms; and believe it or not,

some of the "cranks" have actually been helped a lot with their problems, some of which were mental.

Access to Diagnosis and Prevention

We are often told that Philadelphia is one of the biggest medical centers in the country. Even at that, there is hardly a place where a person who works for wages or salaries can avail himself of medical services for diagnostic or preventive purposes.

There are available in the city a few places, such as the Benjamin Franklin Clinic of the Pennsylvania Hospital, where one can obtain such studies. However, in almost all cases, the charge for these services ranges from \$100 for a routine check-up to about \$200 for an extensive diagnosis of a person's condition.

It is true that these services are excellent and very thorough, but I doubt whether it needs my comment of how many people of our population are in a position to avail themselves of that kind of a service at those prices.

Provision of Hospitalization

One of the biggest problems we have is with hospitalization of our people. Except in an emergency case, that may impair the life of a patient, it very often takes weeks before a member is hospitalized. Particularly is this true of people who do not have some kind of prepaid insurance coverages. The answer on the part of the hospital authorities as to why it is so hard to hospitalize these people is almost always the same.

There are insufficient ward accommodations, and even in cases of emergencies it becomes sometimes necessary to call a police patrol wagon in order to send a patient in for immediate hospitalization, and in some instances even this method results in turning away our people after emergency treatment, or with no treatment at all. In many cases where our people are not covered, as mentioned above, it actually becomes impossible for us to handle the cases, and of necessity the medical centers just must give up and inform these people that they must shift for themselves.

This situation prevails not only in one or some hospitals—our experience is the same with quite a few of our hospitals in the city. Incidentally, this situation exists while in a number of our hospitals complete floors and even buildings are at present not being used in spite of the demand for hospitalization as demonstrated above. In the

very hospital where the A. F. of L. Medical Service Plan is housed, there is a complete building now unoccupied. This formerly used to house 200 beds and has been closed for almost 3 years. . . .

Cost of Hospitalization

As to the cost of hospitalization for our people, we find that in spite of all prepaid insurance plans, voluntary commercial and self-insured, the cost of hospitalization is now so high that by comparison with costs as they were known prior to the initiation of all these prepayment plans on a mass scale, a bigger hardship is placed on the people than many years ago before the plans. For example, in 1942 and 1944 our people would find themselves in a ward where for a payment of no higher than \$28 a week they were taken care of completely, the sum including all expenditures while at the hospital, such as drugs and so forth.

Today the cheapest ward cost is from \$8.50 a day, and runs as high as \$13 a day sometimes for ward accommodation alone, with such items as drugs, laboratory, X-ray and so forth as extra charges.

With the exception of the voluntary plans that cover the actual service of almost the entire cost for the first few days of hospitalization, the members must sometimes pay more than twice the amount of what their coverages provide for, and very often they are discharged with a bill that they do not have money to pay. To meet this situation almost every hospital in Philadelphia installed a system of paying for a week's hospitalization before a patient enters this hospital, some as high as \$90 per week. It should not take much imagination to guess what happens to a worker that must enter a hospital and the first thing he meets even before he is admitted is that kind of bill. In cases where there are no coverages as stated above, the center is just forced to give up its attempt to hospitalize such patients, and in many of the cases this leads to our later discovery that these people, because of their inability to go through with their hospitalization care, have wound up to be cases beyond any possible help later on.

Cost for Surgery

The question of cost for surgery is no less a problem for us than is hospitalization, and even where there are prepaid coverages a number of people are forced to pay for surgery and to make

additional payments in many instances in order to cover the entire cost of the surgical procedure.

In many cases the patient is forced to delay his surgical need until the time he must go through this procedure, and by then very often such cases lead also to pretty serious problems, medically and financially.

Cost of Serious Illness

We have our share, however small it may be, of tuberculosis, mental conditions, long-term illnesses in need of rehabilitation, and incurable cases. With all due respect to the job that is being done in their respective fields by the health and welfare plan of our unions, of our community chest and other institutions dealing with these problems, and even with the aid of city, State and Federal tax dollars, very little is done for the over-all needs of these people, particularly in the above-mentioned categories. And in a very short time, a person afflicted with any one of these diseases almost inevitably becomes a charity case—some of them for the rest of their lives.

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Commissioner ALBERT J. HAYES. Mr. Melamed, do you have any information as to the number of AFL members in this general area who are covered by either health and welfare plans or some form of prepaid medical insurance?

Mr. MELAMED. Mr. Chairman, in the last 2 or 3 years I would judge that we probably have about 75,000 people that would be covered by every kind of conceivable prepaid insurance plan.

Commissioner HAYES. Out of what total?

Mr. MELAMED. We have 230,000 members.

Statement¹ of

MRS. MAURICE WHEELER

Regional Education Director

A. F. of L. International Ladies'

Garment Workers Union

St. Louis, Mo.

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Concern about the health and welfare of its members is traditional with the International Ladies' Garment Workers' Union. In the Southwestern Region, the program for the care of the

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

health of the garment workers is comparatively new and has been worked out jointly with the employers.

In the garment industry it is easy to demonstrate that health is a matter of mutual concern to employee and employer. Because of the piece work system of payment, employees can see a very direct relationship between earnings and health, and employers can readily understand that overhead per unit of production is cut down by having healthy and therefore more productive workers.

The bulk of the garment workers (are) . . . in the income group from about \$1,000 to \$2,500 a year, with some highly skilled workers making more. Their work is seasonal and some layoffs can be expected. This means that the annual income drops, even though hourly wages may be quite consistent.

This income group quite possibly receives the lowest amount of medical care of any in the country. Many of the people are too proud to accept what they consider "charity" from a free or low cost clinic, and haven't had money to pay private physicians. After working with our groups, some physicians have commented that in general they represent the medically unknown—doctors have not seen them, either in the free or low cost clinics or in their private offices.

It was obvious to thoughtful union leaders and employers that among the garment workers there were serious unmet health needs for various reasons; first of all, lack of finances to pay for physicians and dentists care, diagnostic tests, hospitals or medicines.

Inadequate Health Education

Then, because of very inadequate health education so that there were, (a) little understanding of preventive medicine, good hygiene, or adequate nutrition; (b) lack of knowledge of what medical care can do, resulting in an acceptance of physical misery; (c) a fear of doctors and hospitals.

Then, again, when I talked about physical misery, over and over again I have talked to women who obviously need medical care, and they say to me: "My grandmother had the same trouble. Nobody could ever do anything for her. My mother was miserable."

So the fact remains that women are just miserable.

It has been amazing to them to learn that there were doctors who could do something about it for them.

There has been a lack of understanding about what it means to have a qualified specialist, and to learn that there are doctors who treat special problems. There has been an age-old fear of doctors and hospitals. Hospitals are a place you go to die, according to some of them.

They feel that the doctors will tell you there is something wrong, and after they tell you there is something wrong you know it is wrong, and then there is much more trouble.

Availability of Medical Factors

The next point is the unavailability of good health care which is due to lack of arrangements for preventive medical care; also due to an inadequate number of doctors, dentists and nurses, particularly in rural communities.

I have come across areas where I have calculated the availability of doctors was one to 6,000 people, where the doctor told me that he saw 90 to 100 people during office hours and made home calls in addition, and also hospital calls in the next county.

Then, you have the very definite poorer training and ability of doctors available to people who have low incomes or who live in rural areas. When I check on the doctors in some of our small communities, I find available two doctors who graduated from a diploma mill 40 years ago; one chiropractor; one whom I suspect—well, they call him a horse doctor—and I suspect that his degree does come from a veterinarian college; and one new young man from a good medical school.

Guess where they go?

Then there is a patient's inability to judge whether a doctor is a well qualified one or not. This is very serious, because most people believe that because a man has a medical license from the State, or because he belongs to a medical society, that he must be qualified as a doctor, not realizing that he has never been reexamined since his first test and may never have bothered to keep up with advances in medicine. They don't realize that he doesn't know anything about the new things. The patient still believes that when the State says that this is a good doctor, and the medical association says that this is a good doctor, that he must be a good doctor, so they go to him.

Then there are inadequate facilities, such as laboratories and hospitals, both in the cities and

rural areas, but particularly in the small communities.

There are many, many communities that do not have within them—or have available to the doctors in them—X-rays and even such simple physiotherapy things as diathermy. They don't have anything in the way of diagnostic equipment at all.

Then, one of the very serious problems to workers is that care is not available at a time that they can go to get medical care of any kind. When they go to get medical care of any kind, they must give up their wages for part of the day in order to get that medical care.

Insurance Coverage

In the Southwestern Region, the ILGWU has tried to meet some of the health needs by providing in union contracts for employer payments equaling 1 percent to 1½ percent of the payroll for health benefits toward either, (1) the establishment of medical centers for direct service and which are under the trusteeship of a joint union-employer commission; or, (2) group health insurance which provides for payment of bills for hospitalization, surgery, medical care or diagnostic tests, and sometimes for weekly sick benefits.

This health insurance is taken out directly by the employer with a commercial insurance company.

The direct service given at the medical centers much more nearly meets the problems than does the insurance approach to the problem, to which recourse has been made only in communities where we have too few members to make a medical center practical. The Southwestern Region includes medical centers in St. Louis, Kansas City, San Antonio, Dallas. Special arrangements have been made with physicians to care for our members in Houston.

Health insurance meets part of the financial problem and thereby relieves some of the members' concern about the high cost of catastrophe. When insurance includes a certain amount for payment for visits to the doctor, even though the patient is working, it encourages people to get early examination and treatment, thereby preventing the development of more serious conditions. When it also includes payments for laboratory and X-ray tests for cases outside the hospital, it permits the conscientious physician to have recourse

to these diagnostic aids without worrying about the heavy burden of expense to the patient.

However, insurance based on premium payments equaling 1 to 1½ percent of the payroll of this group does not meet all the financial problems.

As an example, the amounts of money involved can pay for approximately the following:

Hospital benefits, \$5 a day for 31 days; \$25 for extra charges.

Surgical benefits, \$150, maximum surgical schedule.

Doctor bill benefits, \$3 for a doctor's visit to home or hospital; \$2 for a visit to the doctor's office.

This, however, applies only to the first visit in the case of an accident, and to the third visit in the case of illness.

However, the cost of insurance is going up, making even those benefits unavailable.

At this level of expenditure, many items of expense are not covered, such as the cost of dental or eye care, nurses' services, diagnostic tests, medicine or appliances. Loss of wages is not covered.

This amount of insurance often does not meet the problem because the regular charges of the physician are more than the policy provides. In other cases it has been apparent that when the physician learned that the patient had insurance, he increased his charges or put on some extra charges. That is a very important prank to note. There has been reason to suspect that there are cases of patient and physician conniving to get unjustified payments from the insurance companies, thereby keeping insurance rates high.

Insurance Is Not Complete Answer

It is important to note that providing insurance to pay the bills by no means solves many of the other unmet problems of health care. It does little or nothing to increase health education; to institute preventive measures and periodic physical checkups; to increase the number of schools for training doctors, dentists and nurses, or to assist the student with the high cost of such training; to improve the quality of medical care—in fact, insurance payments help subsidize bad medical practice; to help the patient select a well qualified physician; or to increase the hospital or laboratory facilities.

Payment of bills through health insurance is by no means the complete answer to the problem of good health care. The establishment of medical

centers goes much further towards meeting the needs when they are adequately equipped, well staffed and give complete care to entire families. Many of these problems, though, are going to have to be met by community effort, either on a voluntary, cooperative basis, or through agencies of the county, State or Federal governments.

However, the International Ladies Garment Workers Union recognizes a need for health care as so urgent that now it is acting to establish the best protection it can for its members, hoping that its efforts will also serve to test methods of approaching this problem and will point the way to other groups and the community.

Statement¹ by

WILLIAM ROSS

**International Ladies Garment Workers Union
New York City, N. Y.**

At the time the garment industry developed, around the turn of the century, it earned the condemnation of all public-spirited citizens for its appalling labor standards, for its overcrowded workrooms, as a breeding place of misery and disease. "Health conditions were scandalous, even by the standards of the day," notes Benjamin Stolberg in his study of the women's garment industry.

Aside from the ailments caused by overcrowding, ignorance, and poverty, the sweatshop bred its own occupational diseases.

Garment workers were notoriously subject to tuberculosis and other pulmonary disorders, to rheumatism and to skin diseases of all sorts, contracted from poisonous dyes in the cloth. The trade life of the garment workers was the shortest of any industrial group. Physicians diagnosed the infirmities of men in their thirties or forties as due to galloping "old age."

Little wonder, therefore, that from the early days of unionism in this industry workers sought ways and means to abolish the sweatshop, to improve the sanitary conditions of the work place, to take care of their sick and disabled coworkers, and to prevent disability.

As early as 1910, at the time the first major collective agreement was concluded by our union in the New York ladies' coat and suit industry, we established a tripartite body, composed of union,

employer and public representation, to police the sanitary conditions in the shops.

Union Health Facilities Established

In 1913, we opened our first Union Health Center, an institution which presently occupies more than 100,000 square feet of space, servicing the health needs of our New York membership as well as assisting in the administration of our sickness and hospitalization benefits in that area. New York City is the major center of the garment industry, and our Union Health Center there is our largest.

Elsewhere throughout the country we established diagnostic clinics—in San Antonio, Tex.; in Boston, Mass.; in Kansas City, Mo.; in Allentown, Pa.; in Minneapolis, Minn., and in Wilkes-Barre, Pa.; in Fall River, Mass.; in Dallas, Tex.; in Los Angeles and in St. Louis; in Newark, N. J.; in Cleveland, Ohio, and in Houston, Tex.—and, of course, here in the city of Philadelphia.

We hope that we will establish such centers in every garment area where we could service at least 5,000 of our members. In some of the smaller areas we are now operating successful clinics on wheels which bring diagnostic service directly to the shops where our members work.

In other instances arrangements have been made with local medical practitioners to serve our members. Thus, in one way or another we manage to serve 75 percent out of a total of 425,000 of our members.

Financing Health Services and Benefits

The medical facilities operated by our union in the main provide service at no charge to our members. This work is financed by our health and welfare funds, supported by employer contributions under the terms of our agreements with them.

Aside from medical services, health and welfare funds also finance disability benefits, contribute to hospitalization and surgical costs, and, in numerous instances, to the costs of maternity benefits, eye conservation, care of tuberculars, and so on, including benefits toward vacations. During the calendar year 1951, the total disbursements from our health and welfare funds exceeded \$25,000,000.

Health of Garment Worker Improved

We have traveled a long way from the days of the old sweatshop. The health of the average garment worker has materially improved, as our

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

union succeeded, through collective bargaining, to raise his standard of living, to lay the foundation for better medical care and to provide some measure of financial assistance during periods of disability.

Despite the generally expected success of our programs, much remains to be done—much more than any single labor organization, in cooperation with the employers of its members, can hope to achieve.

Let me illustrate.

At best, our Union Health Centers provide outpatient service. However, in most areas, as a result of the position taken by organized groups in the medical profession, our Health Centers can only provide diagnostic service—no treatment.

And yet, the provision of medical treatment is essential.

Need for Medical Care

In many instances the cost of treatment is much higher than can be borne by an individual worker, who, on the one hand may be forced to cease work while under care, and, on the other hand, has to finance the cost of medical treatment while deprived of the current income. A chest X-ray survey conducted among 40,000 of our New York members revealed, for example, 31 active and 835 unsuspected arrested cases of tuberculosis, 522 cases of heart abnormalities, 73 cases of bronchopneumonia, 34 lung tumors, as well as many other chest conditions which required medical intervention.

Field activities carried on by our mobile diagnostic clinic in central and western Pennsylvania, which provided 13,045 examinations to 9,601 workers, showed that no need for medical care was found in only 22.9 percent of the examinations.

In 34.2 percent of the examinations, abnormalities were found which were already known to the workers' own doctors.

In the case of the remaining 42.9 percent of examinations, existing abnormalities were found which required medical intervention but which were not known either to the worker or his own physician.

And this despite the fact that 4½ out of every 100 of these abnormalities—unknown to the worker and his doctor—were of sufficiently serious character—such as developed diabetes, lues, profound anemias, severe hypertension, cancer and so on—as to require immediate medical treatment.

Value of Diagnostic Work

The findings which I have discussed highlight the certain values of diagnostic work. They certainly demonstrate that the incidence of cases requiring medical intervention constitutes a much higher proportion of the total than is generally expected, and that in a substantial number of these cases no awareness of abnormalities exists.

Periodic medical checkups, accompanied by the needed laboratory examinations and tests, are thus definitely called for, provided one can afford them.

Our union has been successful in providing such diagnostic facilities for the overwhelming majority of our members. We have not attempted to date to do the same for the members of their families.

If we can take the average size of the family in the United States to be also typical of the families of our members, this suggests that for every one hundred cases for which we provide diagnostic facilities there are probably 260 cases where no such facilities are available.

Aside from diagnosis, the cost of treatment and some compensation for the loss of income by the family's wage earners is also an important consideration.

Sickness Benefits

Here in Philadelphia we manage to provide our members with a sickness benefit of \$10 to \$13 per week up to 13 weeks, after 1 week waiting period. We also provide an additional \$5 hospitalization benefit up to 30 days of hospital confinement, up to \$150 towards the costs of surgery, and so forth.

These benefits, however helpful they may be, are far from adequate and, as I have already pointed out, cover only our members and not their families.

An average worker has to pay \$8.50 for a ward bed or \$12 for semiprivate hospital accommodations, and this does not cover the costs of laboratory examinations. An average doctor charges him \$5 for a home visit. The financial strain on the individual, who is assisted by our Health and Welfare Fund, though mitigated, remains substantial.

Workers Fear Illness Confinement

The threat of a possible loss of the greatest portion of one's current income surely keeps some workers from even finding out at the Health Cen-

ter what, if anything, is wrong—thus for example, one worker out of every four used our Philadelphia Center during the past year. The older group has, of course, a much greater need for medical care. Where, for example, workers under 30 visited the different departments of our Philadelphia Center on the average 7.2 times a year, those over 60 came in 9.7 times per year. The extent of medical needs is, however, not demonstrated by the visits of our members to our center.

One out of every 10 of our members suffered a confining illness of more than 1 week's duration, averaging about 6.3 weeks of confinement per person.

These data are a byproduct of the administration of our sick benefits, which are not paid for the first week of illness; the average incidence of confining sickness is therefore greater than these figures may lead one to believe.

But even more important than this is the fact that averages do not tell the whole story. The most tragic case is not a short illness, a couple of days in duration, but one which lasts beyond the average, longer than the period accounted for or compensated by Health and Welfare funds or any other type of the existing medical insurance.

Modern Medicine Costs Run High

If family savings are adequate, as in the case of the upper income brackets, they might be sufficient to finance such illness. But an average garment worker family, or, for that matter, an average American family is not that fortunate. Long sickness is catastrophic.

As Dr. Louis I. Dublin pointed out some time ago, when the family breadwinner is incapacitated or prematurely killed by disease, the cost of supporting that family is about \$35,000 if the family income annually were \$2,500. Prolonged illness in the family undoubtedly drives many of them to the public assistance rolls.

Illness, however predictable for the population as a whole, strikes an individual when least expected. We have, over the years, done much as a Nation to reduce its toll. But we are nowhere near providing our people with all the benefits which modern medicine can offer. The average person just cannot afford the luxury of proper treatment and disease prevention.

In the old days, notes Senator Douglas in a recent address, "When all the family physician

had to do was to apply the stethoscope to your chest, take your blood pressure, listen to the beating of your heart, diagnosis was a comparatively simple and not too expensive matter. But when you carry out a thorough program of X-rays, when you analyze the blood and urine for almost every conceivable or possible disease, when you carry out the elaborate laboratory work which is now needed, the costs become exceedingly high."

Pooled Protection Against Health Hazards

It is impossible, therefore, to deal with the problem in terms of the individual, or even in terms of relatively large groups such as those covered by our union health and welfare plans.

The pooled protection for the extraordinary emergencies of life—and illness and its prevention are clearly in this category—carried out in accordance with the principles of sound social insurance is the way to provide the needed medical service and facilities and for the loss of family income during disability.

We cannot hope to get each individual or each family to pay their actuarial share of the cost of this protection—many of them just cannot afford the cost however much they need the service.

The costs of such protection will have to be equitably spread out. Protection against disease and against the loss of earnings must be carried out through the instrumentality of government. Such governmental intervention is a necessity in order to compel the payment of the needed contributions, both to assure adequate coverage as well as to avoid adverse selection of risks.

Industry and Nation Benefit

In the long run, however, such a plan is the best and safest investment which we as a nation can make. Although we have over the years increased the life expectancy of our population, let us not forget that in many countries of the world the life span is better than ours—in Canada, in the Netherlands, in Sweden, in Australia and in New Zealand.

If we reduce the toll of disease, if we eliminate some 325,000 preventable deaths per year, if we improve the health of our people and reduce absenteeism due to illness, we will benefit industry by lowering its costs and by increasing its markets—and we will benefit our country. For better health is indeed better business for all of us.

Statement¹ of

MISS EVELYN B. NICHOLSON

Executive Secretary

Garment Industry Medical Center

St. Louis, Mo.

I represent the Garment Industry Medical Center which offers a medical care program sponsored by the Associated Garment Industries and the International Ladies' Garment Workers' Union.

Some 6,000 workers employed in approximately 100 different firms in the ladies' garment industry are serviced by the program. This group of workers is predominantly female, about 90 percent. Approximately 1 out of each 10 workers is colored. The average age of the women serviced is in the upper forties. About one-half of the women are married, and more than 40 percent of the women between 30 and 49 years old have children under 18 years of age.

The great bulk of all employees in the industry are paid on a piece-work rate system, and the industry has certain seasonal tendencies. When they are working on a piece-work base system, if they don't work, they don't eat. As I said, the employment, of course, is seasonal in nature.

The plan is financed entirely by the employers and governed insofar as broad policy decisions are concerned by a board of directors equally representative of labor and management.

Physician Staff

Medical matters are under the supervision of a medical director who is chosen after consultation with both medical schools and prominent qualified persons in this community. There is no interference by the lay board with the functioning of the medical staff. The medical staff consists of 16 doctors, plus 3 consultant physicians, representing the specialties of internal medicine, gynecology, the genito-urinary, ear-nose-and-throat, and eye, surgery, orthopedics, dermatology, and psychiatry.

All but three of these doctors are certified, and these three will shortly be certified, or we expect them to be so certified.

None of these doctors are on a full-time basis. Each is engaged in private practice. The certifi-

cation I referred to for the three doctors are certifications by their respective American specialty boards. As I say, we expect these three to soon be so certified.

Adjunct services include X-ray, laboratory, physiotherapy, basal metabolism readings, electrocardiograms, and social service.

All of the services are grouped under one roof. . . .

Conditions of eligibility for service are (1) that the worker be employed in a shop covered by the program, and (2) that he be a member in good standing of the ILGWU.

Program Services

The medical program includes reasonably complete diagnostic and treatment services such as can be properly rendered on an out-patient basis. There is no financial charge to the patient for any service so rendered.

No prescription medicines are supplied at the medical center. Only those medicines and drugs which the doctor prescribes to be given by injection are furnished, and these, of course, without charge. Arrangements exist with a local pharmacy whereby a patient's medical center prescription will be filled at a reduced rate. No eye glasses are furnished, but here again an arrangement exists with a local optical firm. If a patient desires to avail himself of this service, he does so at a greatly reduced rate.

Now, I would like to direct your attention to the extent this particular program meets the health needs of its patients, and then consider its inadequacies or shortcomings.

Quality Medicine

From the economic standpoint, of course, it is obvious that a program of high-quality medicine is available to the patient without charge, but further than that, of considerable importance, too, is the fact that particular attention has been paid to making medical care accessible so that the patient suffers a minimum loss of earnings.

For instance, all patients are seen by appointment; doctor hours are arranged to provide a maximum of off-work time appointments, all services are provided under one roof, and medical studies and specialists' opinions are furnished to nonstaff physicians without charge.

Again from an economic angle, it is believed that a conveniently available program of preventive medicine results in many instances in safeguard-

¹ Delivered at the Regional Hearing at St. Louis, Mo., September 15, 1952.

ing against or reducing the duration of prolonged illnesses, and that the medical program may often eliminate hospitalizations, and in other cases reduce the duration of hospital stays.

Of course, quality medicine represents a plus value to the patient.

On this business of appointments with the doctor, if the individual has to wait more than 5 minutes from a point of time, there is some breakdown in the system. All of this is important from the standpoint that if these people are away from their jobs they suffer a loss of earnings, and medical care is set up and so offered that the employee does not lose time off from his job.

Aspects of Quality Medicine

Now, let me talk for a moment as to why we call this quality medicine. First, the medical staff consists of well-trained and well-qualified doctors.

Secondly, these doctors are conservative in their approach to the patient's problems.

In other words, no unnecessary surgery is being done at the garment industry medical center or by any member of the garment industry medical center staff.

The staff views the patient as a whole.

All of the advantages of group practice exist. The patient has a team of doctors to meet his medical needs. They consult freely with one another about his problems, and there is no limitation on the use of auxiliary medical facilities.

Of course, the confidential relationship of the patient is fully protected—it is protected in all respects.

The patient is referred to social service and every effort is made to help him gain maximum receptivity and response to treatment.

An attempt is at least being made to try to solve the problems of the patient with psychosomatic complaints.

By and large, the members of the industry have a feeling of pride of ownership in the medical center, and in increasingly large numbers seek its services.

A study made prior to the time the medical center opened showed—and this was on a sample questionnaire basis, the authenticity of which correlates very well, but for the accuracy of which we cannot vouch absolutely—that approximately three patient visits per individual per year would be made.

Up to this time—and the medical center has now been in operation about 5 years—a little over 4,500 individual patients have received medical center service, with about 14 patient visits per person per year. This is on an entirely voluntary basis, since there is no element of compulsion exercised.

Moreover, there is no indication that the people serviced at the medical center have any feeling that they are getting a charity type of treatment. We see no reason to feel—or rather, we see no indication that they feel that their human dignity is being violated.

Health Education

A health education program is being carried out, and the group is being educated to good medical care. Detection programs are also being carried out.

More and more patients are coming in for annual health examinations. Many are seeing a doctor when they otherwise would not; many are seeing a doctor earlier than they otherwise would; and most are seeing a doctor oftener than they would under other circumstances.

All are getting good medical care when they come. Some see a doctor elsewhere than at the medical center, some before they come to the medical center, some afterwards. We have seen many examples of this type of patient being better able to evaluate his medical needs by reason of his medical center services.

Now, wherein does the medical center program fail to meet the health needs of this group? Broadly, of course, it is self-evident that meeting the health needs of any group is a comprehensive problem involving many socioeconomic factors. No medical care program alone can answer this.

A Limited Medical Program

But from the standpoint of medical care alone this program fails principally in that it is a limited rather than a complete medical program. It was set up with the idea that it was preferable to use the funds available to provide a limited amount of care of high quality, rather than to attempt to spread the base at the sacrifice of quality.

The program covers only the employed worker—it does not include members of his family. It is, of course, axiomatic that an individual's state of health is frequently adversely affected by the unmet health needs of members of his family.

No home calls, and no hospital services are provided under the program. This all too frequently results in neglect by the worker to take desirable and sometimes imperative health remedial measures. In other cases, it results in a lack of continuity of medical care.

No dental care is offered.

Perhaps also I should add that with certain of the shops out of St. Louis serviced by the program, indications are that distance and transportation problems seriously hamper proper utilization of the medical services offered.

In conclusion, let me remark that we feel that the garment industry is making a vital contribution to public health in the community. We hope that future developments will make possible a greater contribution in the future.

Statement¹ by

DR. JOHN MCNEEL

Medical Director

Labor Health Institute, Inc.

St. Louis, Mo.

The St. Louis Labor Health Institute was established in 1945 as a group medical practice plan designed to offer the best available medical care to a group of people with low incomes, who were members of a small local union.

In the beginning there were 1,000 members. At the present there are about 15,000. The members of the Labor Health Institute represent a group of wage earners whose average earning capacity in 1945 approximated \$140 a month—in 1949, \$170 a month, and now in 1952, \$240 a month.

The purpose of the institute was to afford low-cost medical care to people who could not meet medical expenses. Through collective bargaining with the employers, the Labor Health Institute provided the means to finance this medical care program.

Basic Philosophy

The basic philosophy upon which the Labor Health Institute is predicated has remained unchanged. The approach continues to be biological rather than pathological. Good health is much more than the absence of sickness. It is a very positive thing which begins with hereditary factors and is conditioned by environmental factors

such as climate, economy, and emotional state. Treating the symptom is only one aspect of the work of the Labor Health Institute doctor. Because the doctor understands that a human being is a part of his environment and is healthy only when he synchronizes his life with his surroundings, the doctor treats the total personality. The Labor Health Institute doctor realizes that sickness is a result not only of germs, but of poor nutrition, poor housing, inadequate clothing, emotional frustration, overcrowded cities, and even the exploitation of the soil.

The Health Conservation Program is at its beginning stage but considerable thought and promising steps are being taken to make it a major function of the institute. The Labor Health Institute is engaged more in the pursuit of health than in the pursuit of sickness and will continue to make health conservation a motivating force in the program.

Health a Community Problem

The institute believes that health is not an individual but a community problem, because the health of each individual affects the health of his neighbor. Therefore, the Labor Health Institute invites not only union and management participation but offers its services and cooperation to promote the health of the community. The care of sickness and the conservation of health have a direct effect upon the livelihood and welfare of all individuals. Sickness and germs know no racial, economic, political, or geographical barriers.

The philosophy of the Labor Health Institute has been put into action through group medical practice because the institute believes that medical care is not an individual matter. One physician alone is not capable of handling effectively the total job of preventive care, diagnosis, and therapy. With the growth and expansion of specialties in modern medicine, this is becoming more apparent and it is clear that only group medical practice is the answer to the best medical practice.

Group medical practice brings to every patient all of the skills possessed by general physicians, specialists, dentists, technical workers, and social workers which are essential for the maintenance of the highest standards. Because the activities of all of these professional people are coordinated in group practice, more and better service is rendered to the individual patient.

¹ Delivered at the Regional Hearing in St. Louis, Mo., September 15, 1952.

Traditional Patient-Doctor Relationship

The Labor Health Institute maintains the traditional patient-physician relationship. Each patient is assigned a personal physician among the members of the general staff, but above and beyond this traditional relationship all specialists and consultants are available to the patient when he needs them.

The interest in health and welfare of its members by one union is a direct extension of labor's preoccupation with the health needs of the Nation, which for the most part have been ignored by the legislative apparatus of Government.

Under the impetus of collective trade union action, the shorter workday and week has become an integral part of our industrial community. Other gains that have been accomplished through the trade union movement have been the formulation of safety laws and workman's compensation benefits; the abolition of child labor; enactment of unemployment and disability insurance; paid holidays, vacation and sick leave; hospitalization insurance and retirement plans.

With the development of the health and welfare clauses within the collective bargaining processes the trade unions have become increasingly active in the field of the health of their members and their dependents. Although this movement into the health field was given great impetus by the enabling legislation referred to, the interests of the union in the health of the members date to earlier fraternal and other quasi-social types of organization guaranteeing some protection against sickness and accident.

Basic Inadequacy Is Economic

The chief reason for the inadequacy of medical care is economic.

There is a great awareness among trade unionists and the recipients of health and welfare benefits that the unpredictable and high costs of medical care are met only by a small percentage of the large middle income group which will require the services of preventive and curative care.

The scope of the medical services that can and should be provided should be a chief concern of the Commission.

The public requires a comprehensive medical care program at a cost which people can afford to pay, and the ready availability of such comprehensive medical services to ambulatory persons is

vitaly important for disease prevention and for the early disease detection. In this age of highly specialized professional skills and medical technology, the total medical needs of a population can best be met by a well-balanced group of physicians, specialists, and technicians trained in a variety of skills and techniques which today constitutes modern medicine. It should be the purpose of the medical profession to combine these medical skills and techniques in the form of group practice so as to be able to place them fully at the disposal of people of moderate means in return for the income received from their insurance premiums.

Content of Medical Care Program

A medical care program that would be of full value should include medical services by general physicians and specialists in the office, the home and hospital. It should include all the preventive medical care, including periodic health inventories as well as curative and diagnostic care; refractions and glasses, hospitalization; rehabilitative services; medication and other sick room supplies; dental care; public health nursing service in the home; laboratory and radiographic services; ambulance services; surgical appliances and other auxiliary benefits.

To attain these objectives, prepaid group practice offers the most ideal method. To the medical profession for the most part this is an acceptable approach. The entire profession strongly advocates voluntary medical insurance. But there is strong opposition in certain sectors of the medical profession for a combination of these concepts.

The comprehensive program should be available without limitation as to the number of services, age, sex, color of the eligibles and other artificial barriers. Furthermore, the programs must assure the people of a high quality of service by physicians qualified, in accordance with the highest professional standards. Medical group practice must be permitted to continue to point the way to the most efficient use of the professional knowledge, skills, technical and other personnel and equipment. Reasonable safeguards should be established to prevent abuse either by patients or doctors.

As an example of what has been done for a group of 15,000 members of the Local Teamsters Union No. 688 receiving service at the St. Louis Labor Health Institute for the calendar year 1951, the following statistics are quoted:

Six thousand two hundred and ninety-seven members used the services; 22,402 general physicians' services; 37,440 specialists' services; 5,699 radiographic visits; 8,171 diagnostic laboratory visits; 18,776 dental services; 3,425 home visits; 1,175 visiting nurse calls at home; 1,436 hospital bills paid; 896 physiotherapy visits.

Medical Care Problems

The above physicians' services were provided by general physicians in 10,000 hours and by specialists in 14,000 hours and by dentists in 9,000 hours.

The general medical care problems of the workers and their families may be summarized thus:

First, the security and well-being of the worker depends upon his continued good health.

Second, the source of payments for all medical service is still primarily the individual patient despite the rapid growth of public and voluntary programs.

Third, the cost of care for family dependents makes up over 3 quarters of the annual medical bill for the average worker and is thus an essential factor in any plan for adequate medical care.

Fourth, illness is a major cause of work time lost and decreased efficiency in industry.

Fifth, the quality of medical care is as important to the worker as are the costs. That has not been emphasized so much in these meetings.

Sixth, many different public and voluntary medical programs have been developed throughout the country. Only a tiny fraction of the population receives comprehensive family health service under these arrangements, recent data showing that less than 12 percent of the Nation's total private medical bill is defrayed by all these programs combined.

Seventh, in partial answer to the wide area of unmet needs, since 1945 there has been a rapid development of union-management health and welfare plans negotiated under collective bargaining.

Eighth, as an expression of many unsolved problems in this field, a great amount of health legislation has been introduced before national and State legislatures.

Ninth, the conclusion seems inescapable that the major area of progress in the medical care field during the coming period will be that of labor-management cooperation in negotiated health and welfare plans.

Statement¹ of

JOSEPH LANGBORD, M. D.

Medical Director

**Sidney Hillman Medical Center of the
Male Apparel Industry of Philadelphia, Pa.**

Ours is a pioneering medical program adapted to serve the great majority of our population in the low- and moderate-income groups. The program can be made possible by the combined efforts of industry and labor or by community cooperation.

In our case it is sponsored by the Philadelphia Men's Outer Apparel Industry and the Philadelphia Branch of the Amalgamated Clothing Workers Union of America. This plan offers a scientific method of approach to one of the most complex and distressing problems of our day: namely, the better distribution of modern medical care to those in the low and moderate economic strata.

This program is dedicated to provide adequate preventive, diagnostic and specialist service to the many ambulant worker-patients, in addition to a wide coverage for catastrophic ailments, hospitalization, surgical and obstetrical fees, and so forth. We feel that by our mode of operation, we do not in any way infringe upon the economics of the medical profession.

Management and labor's entrance into the field of medical service for the benefit of its member workers is as natural as it is for water to roll down a mountain. Think of the worker who is raising five children in a four-room house or four children in a three-room apartment. In some instances, even with his limited income, he manages somehow to budget for hospitalization, and in most cases he budgets for the care of acute ailments treated at home. What the worker with a limited income cannot do is to budget for modern ambulatory preventive medical care as we understand it today.

Our present-day concept of preventive medical care is that competent and skilled physicians, modern technical equipment and well-trained technicians who integrate their efforts for the purpose of detecting disease are required in the early transition period between good health and disease. . . .

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

Health Objectives in Preventive Medicine

Obviously, it is during this period that the most can be accomplished. It is equally important to establish a conclusive diagnosis in more advanced cases so that adequate medical care can be instituted with the view of either staying or curing the disease, and thus preventing such cases from becoming bedridden patients.

The second objective of such service is to provide the best corrective therapy for those suffering from chronic occupational ailments and degenerative disabilities—and thus reduce the patient's discomfort and help the worker to stay on his job.

Third, health education, which is a most vital element in a preventive medical set-up.

Unfortunately, the required quantity and quality of preventive medical service is most unpredictable and therefore unbudgetable. Such insurance is not covered by any commercial insurance company nor by any prepaid profit or non-profit group because such service, to be effective, must provide unrestricted ambulatory preventive medical care whenever the need arises.

Comprehensive Insurance Unavailable

To my knowledge, there is no such insurance coverage available. The conventional outpatient department of the average voluntary hospital is certainly no substitute for the modern preventive medical care plan. If that department is to become an important community medical service station, it will have to be operated on a par with the hospital in-patient's service, where the accommodation of the patient load is fixed by the number of patients that can be adequately served—the contributing factors being the size of the medical staff, the number of auxiliary personnel, the space and equipment and the number of patients that can be conveniently absorbed by the clinical laboratory and the X-ray department, and the ability of the records department to accurately process the records of the daily patient load. This can only be accomplished by the adoption of an appointment system and by operation on the same level as the in-patient department.

I stress this point because it has a bearing on the subject matter which I am about to discuss. Medical authorities and public health officials have repeatedly pointed to the vital importance of the practice of preventive medicine.

Largest Expenditure Goes for Catastrophic Cases

Yet when we analyze the expenditure of the medical dollar, we find that the major portion goes toward hospital care of catastrophic cases; but a fraction of the dollar is spent for prevention of disease. Taking good care of the ambulant near sick and the ambulant potential hospital case by helping to keep them on their feet and on their jobs is not only good preventive medicine in action but also good economy.

Our faulty allocation of funds for medical care is evidenced by the fact that approximately 90 percent of our medical dollar is spent for 10 percent of the patients, those who require hospitalization, and 4 percent for the hospitalized obstetrical cases. Nothing is allowed for the 12 percent who are treated at home and only an insignificant portion is assigned for the remaining 74 percent of our ambulant sick population. Not only is this group greatest in number, but it is the segment from whom the greatest returns may be anticipated.

The following data clarifies this picture:

Gratifying Progress in Treatment

During our first year of operation we were called upon to study and treat 6,000 of our members, of whom approximately 150 were hospitalized. The remaining number received the most scientific and unstinted medical service on an ambulatory basis.

This includes neuropsychiatric patients and chronic degeneratives and occupational ailments. These two groups make up 30 percent of the patient load of the private physician and public clinics.

Unfortunately, therapeutic progress in their behalf is rather negligible because these patients have been relegated to the incurable pile. Our experience with scientific and energetic treatment applied to these patients has proven to be most gratifying.

Our psychiatric program, consisting of group therapy, carbon dioxide therapy and shock therapy on an ambulatory basis has rendered many of our patients easier to live with and more fit for their jobs. Our Physical Medical Department, under the supervision of two certified psychiatrists, and staffed with well-trained and highly competent therapists in the fields of physiotherapy and corrective therapy, has accomplished excellent results in the treatment and rehabilitation of those suffering from occupational ailments and degenerative diseases of the musculo-skeletal system.

Group Practice—Percentage and Cost

From our years of personnel experience with group practice we found that an average group of people varying in size from 5,000 and over will produce approximately 24 percent medical consumers per annum. As in our own case, with 25,000 members of the Amalgamated Clothing Workers Union, six thousand or 24 percent availed themselves of the center's service, 96 percent of whom were found to require medical care.

Our cost of operation for the year was approximately \$350,000, which is equal to about \$15 per capitation or about \$60 for the care of each one of our 6,000 active cases.

These services are made possible by our health and welfare pay roll assessment of 5¾ percent, assumed by the industry, allocated as follows: 2 percent for life insurance policy, hospitalization, recompense for surgery, and obstetrics, 3 percent for a retirement fund—which provides the members \$50 a month at the age of 65, and ¾ percent for the maintenance of the medical center.

Let us pause to study the cost of operation of a 200-bed hospital, which usually has a bed turnover of about 23 times per annum per bed. In that case it would be able to accommodate approximately 4,600 to 5,000 patients annually. On the basis of current hospital bed maintenance which is about \$15 or \$16 a day to treat a group the size that we service at our center, the hospital operation would cost at least 1¼ million dollars, not counting the loss in time to the worker and the effect of absenteeism to industry. It must be understood that our Center functions mainly during the hours which least interfere with the worker's productivity.

Clinic Hours and Services

While it is open 49 hours a week—from 9 a. m. to 6 p. m. daily and from 9 a. m. to 1 p. m. on Saturdays—the majority of the clinics are held in the late afternoon or on Saturday mornings, so that the patients may attend outside of working hours.

Laboratory and X-ray service, however, is available at all times. All services are completely free and totally unrestricted. Every patient is first seen by an internist who takes a complete case history and makes a complete physical examination, regardless of the complaint. The following studies are routinely done on every patient:

A complete blood count, a complete urinalysis, a photofluorogram and serology. Female patients receive all these studies plus gynecologic investigation.

In addition, any other laboratory or X-ray study, or any consultation with any one of the subspecialists in the field of medicine or surgery that seem indicated in that particular case, will be referred for study and recommended treatment.

Initial Internist Makes Final Diagnosis

Ultimately, the patient is returned to the initial internist with the results of all the various studies. The internist then makes his final diagnosis in the light of all the salient findings and outlines a program of therapy. If the treatment is such as can also be carried out on an ambulatory basis, the program is pursued in the clinic. If facilities outside the center are required the patient is referred to the Public Health Department for the necessary arrangements.

If, however, the problem is not satisfactorily solved the patient is referred to the medical consultant for further study and diagnosis.

Monthly Staff Medical Discussions

The entire medical staff meets monthly for discussion of the most recent medical discoveries and for the presentation of the most complex cases discovered during the previous month.

To demonstrate the value of intensive investigation of patients with vague and indeterminate complaints, permit me to give you the following statistics which cover just the first year of our operation. These are cases which have been picked up in our center but which would have escaped detection had it not been for the intensive survey outlined above. All these cases are being followed by our Public Health Department.

1. Questionable malignancy-----	50	10. Solitary nodules of lung-----	8
2. Diagnosed malignancy-----	20	11. Special follow-up-----	268
3. Apparently inactive TB-----	45	12. Group psychotherapy-----	95
4. Active tuberculosis-----	10	13. Nutrition instructions-----	1,454
5. Positive serology-----	69	14. Hospitalization and convalescent care-----	104
6. Lues-diagnosed--	36		
7. Diabetes mellitus-----	54	Total active case load---	5,071
8. Electroconvulsive therapy--	45		
9. Carbon dioxide therapy-----	85	New-----	3,052
		Old-----	2,019

Medical Care Today Likened to Fire Department

I take it for granted that the objective of this meeting is not to discuss or to propose new curative techniques or new methods of medical care for the sick and the maimed. If I interpret correctly, what is expected of us is to present health plans that would best serve to sustain the health of our people.

Surely commercial insurance policies will not do that. Neither will a voluntary hospitalization policy do it. Nor will a fee for service group plan accomplish such an end. The very purpose of these agencies is like that of our police and fire departments. When trouble breaks out they are expected to come to the rescue of those endangered.

Modern medical care should not be held in reserve for the benefit of the expected physical bankrupt. Instead, it should be exploited to the maximum for the benefit of the health needs of our Nation. It should be directed towards the maintenance of the health of our people and the prevention of disease. When, however, a patient is found suffering with disease, the same armamentarium employed for the prevention of disease is utilized for the cure.

Broad Application of Program Visualized

It must be understood that our program is not custom-made for the specific use of our people. It could well be adopted by church groups, community groups, fraternal and social organizations, and so forth. It could well be financed either on the basis of our plan or by whatever means a given group decides to adopt. What matters most is the establishment of a feasibly functional medical center staffed by a competent and sympathetic personnel who are fairly remunerated for their services and whose enthusiasm about their work is sustained. This reveals itself by the reports of the satisfied consumers.

Human service is an intangible commodity which can only be measured by those who produce it and those who receive it. If we accept this premise to be accurate then we must agree that the quality of our service is good. This conclusion is based on the fact that of all the 135,000 services which we rendered to our people during our first year there was not a single complaint registered. Furthermore, the approximately 2,000 physician-referred patients during our first year of operation

indicates the high regard in which we are held by the medical profession.

The esteem in which our center is held by our teaching institutions is reflected by the fact that two of our best medical institutions in Philadelphia send their students to our center for instructions in public health and modern ambulatory industrial medical care.

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Commissioner ALBERT J. HAYES. Dr. Langbord, do you have any information or any views of your own as to the percentage of the total work force in our country that have the advantage of a plan such as the ACW plan that you have briefly described here?

Dr. LANGBORD. I do not know the definite number. I know that of the 62 and a half million workers in America, I doubt that more than a million and a half enjoy such privileges.

Statement¹ of MR. NICHOLAS KIRTZMAN

Regional Director

International Ladies' Garment Workers Cleveland, Ohio

The International Ladies' Garment Workers' Union, AFL, the Union which I represent at this hearing, takes pride in the historical fact that our pioneering in providing for the health needs of our members has been followed by many other trade unions and socially minded groups. Our first Union Health Center opened its doors in New York City in 1913. Now 18 Union Health Centers stretch across the United States, serving 430,000 ILG members.

Our Cleveland Health Center was opened for service in February. The Union Health Centers, however, are only one aspect of the ILGWU's health and welfare program. A number of welfare benefits supplement our diagnostic clinics. These are sick, surgical, maternity, tuberculosis, and eye conservation benefits. These benefits provide a minimum of financial assistance.

The ILGWU's comprehensive health and welfare program grew out of the needs of our members. Illness is a calamity to any person.

But illness falls with terrible weight upon the worker whose savings are slim and whose re-

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

sources are usually bounded by the weekly pay envelope. In the ladies' garment industry, where employment is seasonal, when serious illness strikes the breadwinner, the effect is catastrophic.

Health Benefits and Service

The Health and Welfare program of our Union attempts to cushion the effect of serious illness; our Union Health Centers attempt to prevent illness. Years ago, the International was instrumental in wiping out the sweatshops in the garment industry, and today we are providing benefits and service to our members so that they may receive proper medical care and have the opportunity to achieve and enjoy good health.

While our members, through their Union, receive the benefits of a medical program which as yet is not as adequate as we would want it to be, the plight of most Americans with respect to medical care is pitiful. It cannot be asserted too often that the ultimate source of a nation's strength is its people, and that healthy people, healthy men, women and children are a nation's greatest asset. Good health is essential to the security and progress of a nation and the promotion of its general welfare. It maintains and improves the efficiency, security, and general well-being of the people. It promotes maximum employment and production and increases progressively the standard of living, the welfare and happiness of all. The maintenance and preservation of good health of everybody by preventing illness in advance and hastening its cure after it occurs must forever be our Nation's concern.

Union Proposes Measures

The great problem now facing the Nation is how to bring adequate medical care within the reach of all our people, how to alleviate the shortage in doctors and hospitals, and how to bring the benefits of a public health program to the countless communities which do not have one. To meet these problems, and others, our Union supports the enactment of a national health insurance and public program by the United States Congress, the purposes of which would be the following:

1. To train more doctors, dentists, nurses, hospital administrators, medical and X-ray technicians, and others;

2. To advance medical research to enable it to discover the causes and cure of diseases and illnesses;

3. To expand hospital building programs;

4. To help rural and other shortage areas build medical facilities to assist farmers' experimental health cooperatives;

5. To expand State and local public health services;

6. To increase maternal child health and crippled children's services; and

7. To provide national health insurance through contributions by employers and workers to cover medical bills and thereby effectuate the above program.

This proposed program is an intelligent, humane, and constructive plan to conserve the health of the American people through national insurance and to provide every American family which requires medical care with the best that money can buy, paid through a pooled fund to which every employer and worker contributes a percentage based upon the worker's wage.

* * * * *

Cleveland ILGWU Health Center

The brief experience of the Cleveland Union Health Center points up what a more adequate, more comprehensive program would mean to the American people. Our Health Center, by agreement with the Cleveland Academy of Medicine, provides only diagnostic services for the five thousand members in the Cleveland area.

Of all our 18 centers throughout the country, only the Union Health Center in New York City provides ambulatory medical care. Because an eye conservation program is so vital to garment workers, our Union was hopeful that the fitting of glasses and complete eye care could be provided by our center. This hope has not as yet been achieved because the medical profession will not permit fittings and treatment in our health center. Another inadequacy in our Union Health Center program is the noninclusion of spouses and minor children. . . .

Under the Cleveland ILGWU Health Center program, each union member is entitled to one comprehensive physical checkup annually, a checkup which includes every medical specialty. A summary of the statistics for the first 6 months' operation indicates what a boon even this preventive measures is to workers who cannot afford expensive clinical examinations.

Persons who never in their lives visited a physician were examined. Others who only visited

a doctor when serious illness struck indulged in the luxury of a thorough physical examination. Many of those examined had no family physician to whom the reports could be sent.

Our examination program already has indicated a fear on the part of those who never could put aside money for medical care—preventive or otherwise. This fear manifests itself in a refusal on the part of some to be examined—even though the examination is a right with no expense involved. The fear is real—it is the fear of discovery of serious illness.

Indeed a number of spectacular cases have gone directly from the examining room to a hospital bed. When these annual checkups become routine and each member will have experienced a number of them, fewer serious diseases in late stages will be uncovered. It is hoped that soon there will be a medical care program—either under union auspices or preferably under public auspices so that all Americans can participate—to supplement our preventive medicine program. Then—and only then—will our union's health and welfare program be fully meaningful to our members.

Union Health Survey

In the 6-month period ending August 31, 1952, 631 Union members received health surveys in the Cleveland Union Health Center. They were examined by 32 part-time physicians, all specialists in their fields.

These members received a total of 7,010 services, which included electrocardiograms, audiograms, allergy consultations, chest medicine consultations, dermatology consultations, general surgery consultations, genito-urinary consultations, neuro-surgery consultations, orthopedic consultations, plastic surgery consultations, gynecology consultations, eye, ear, nose and throat consultations, dental surveys, X-ray procedures, fluoroscopies, basal metabolism tests, and laboratory procedures.

Of the 631 members examined, 513, or an amazing 81 percent, needed medical attention. Much as our union would like to provide ambulatory medical care for these members who need medical care, our agreement with the medical profession does not permit us to provide this care.

The limited experience of our Union Health Center indicates that people with the income range of garment workers—and the income of garment workers, while derived from seasonal work, is

generally above the national average—cannot afford adequate medical care. Our diagnostic center is part of the answer for a handful of union members.

Health Goals

It is no answer for the more than one million people who live in the greater Cleveland area. The goal of our center is to provide every medical service possible in an ambulatory clinic. These services should include physical therapy, electrotherapy, hydrotherapy, psychiatric care, treatment of the geriatric patient, diabetic, and other services. Only then will our members have adequate medical care. They certainly cannot pay for adequate medical care individually. But this goal is a long way off. It will be reached in the face of opposition from the medical profession. It will, nevertheless, be reached because the garment worker through his democratically controlled union will demand it.

But what of most Americans who do not belong to a union with a tradition for the social welfare of its members? Where do they receive adequate medical care for themselves and their families? Because the International Ladies' Garment Workers' Union is concerned about America and its people, we support a broad program of national health insurance and public health for the entire population. The medical services won by our members will dovetail into any public program. The tremendous problem of the health of our people will only be solved in the same manner that the problem of the social security of our people was solved—by public action. A comprehensive national health program is the least the American people deserve.

Statement ¹ of

MRS. ARLIN ADAMS

Chairman of the League of Women Voters of Philadelphia, Pa.

The basic concept of a health center is that of a team of qualified public health workers who would plan and provide services for a clearly designed and designated unit of population. It should have the following function:

(1) To make basic public health services more accessible to all members of the community.

¹ Delivered at the Regional Hearing in Philadelphia, Pa., August 11, 1952.

(2) To coordinate health and related services by all health agencies.

(3) To prevent overlapping of services by all health agencies.

(4) It should study and manage specific problems within the area.

(5) It should act as a focus for the dissemination of health education.

(6) Finally, it should provide adequate health services more effectively and efficiently.

We feel that each health center or health unit should have as an administrator a physician serving full time, trained in public health, with administrative ability. There should be a representative citizen's committee affiliated with the health center as part of the program to study the needs of the area and to interpret for the community the needs of the community and the methods by which the center will service the needs.

There is little doubt that one of the most important functions a health center should perform is preventive medical services. Mental health

should come within this category and should be considered in each phase of the relationship of the individual and the health center. Public Health nurses and social workers should have opportunity for in-service mental health training.

At present the average Philadelphian thinks of a health center as a place where poor people go for immunization or prenatal care. The public must be educated to know what the health center's responsibilities truly are. The City Health Department should disseminate information regarding the improved and expanded services as each is put into effect. An important function of the representative citizen's committee would be to spread this information throughout the community. The health center therefore will be expected to serve every person.

Through the establishment and use of good health centers we can look forward to the full release of all the creative and productive powers of each individual and their constructive employment for the community and for humanity.

HEALTH INSURANCE

BLUE CROSS

Statement¹ of

MR. WILLIAM R. McNARY

**Michigan Hospital Service
Detroit, Mich.**

2,689,248 people were enrolled in Michigan Blue Cross Plan as of August 1, 1952. This is 42 percent of the State's population. In the metropolitan areas, the percentage of the population enrolled in Blue Cross is, of course, much higher. For instance, about 9 out of every 10 auto workers are enrolled in Blue Cross.

More than 90 percent of all Blue Cross members are enrolled through 12,662 groups, of which 1,054 are farm groups. The range of industries, businesses, and professions covered by Blue Cross is, as one can see, very wide. These groups vary in size from five subscribers, the minimum number required, to the General Motors group of 160, 501 subscribers.

Comprehensive Group Contract

Of the 2,689,248 Blue Cross members, about 90 percent are covered by the comprehensive group contract. This contract provides for subscriber and dependents alike up to 120 successive days of continuous hospital care each, with no dollar limit on any of the benefits it covers. After the 120 days of continuous care have been used up, a waiting period of only 90 days is necessary before another 120 days become available on the same terms without any dollar limit on the benefits. The Blue Cross benefits cover about 93 percent of the items that appear on the average hospital bill.

What the Blue Cross comprehensive group contract means to the people on the farms, in the factories, in the stores and in the offices can be guessed from the fact that, on the average, of every 80 minutes of the day, each working day of the week Blue Cross pays a hospital bill of \$1,000 or more for one of its members. A large number of bills run as high as \$2,000. We have had one bill for as much as \$7,000.

... Most of the workers in Michigan no longer have to worry about the cost of hospital care, either for themselves or their dependents.

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

And the hospitals no longer have to worry about the ability of the workers to pay for their hospital care.

* * * * *

Blue Cross Coverage

Blue Cross covers more than 100,000 men, women, and children on Michigan's farms. These people enjoy the benefits of the comprehensive group contract, the same as the industrial workers. The Farm Bureau and the Granges make up the "collection groups" through which enrollment of the rural population is handled. No less than 79.4 percent of all the member of the enrolled groups who are eligible for enrollment are in Blue Cross today. Blue Cross has worked hard for years to achieve this objective because it believes that its program must be universal.

The Federal government refuses to authorize payroll deductions for its employees. Well, if Blue Cross cannot provide coverage through payroll deductions, then it will use another method, the method of collecting by voluntary collectors within the group. We have enrolled 197 groups of Federal employees handled by the voluntary collector method.

We have 68 groups of State employees, 124 county employee groups, 173 municipal employee groups, 431 groups in educational institutions, and a large number of ministerial groups covering the churches.

Large numbers of professional people cannot be enrolled either through payroll deduction groups or collection groups. Blue Cross has enrolled the pharmacists through the Michigan State Pharmaceutical Association, the nurses through their State Nurses Association, the lawyers through the State Bar Association, the dentists and their assistants through the State Dental Association, the doctors and their assistants through the Michigan State Medical Society.

Sheet metal workers and building trades craftsmen may work for half a dozen employers in the course of a year, making payroll deductions impractical. Blue Cross has arranged to cover them by group enrollment through their labor unions. On the other side of the coin, Michigan Blue Cross works through trade associations to reach the employees of small business firms with strong trade ties such as florists, nurserymen, the barbers' association. Each member of the trade association contributes to a central fund making trade-wide coverage for the employees possible.

A Nongroup Program Also

How about those who cannot join through a group, through a trade association, a professional group or a labor union? For these we have a nongroup program. Each year, for a period of 3 to 4 weeks, we open enrollment to individuals on a State-wide basis. Any citizen under 65 can join. No medical examinations are required. There is a waiting period of only 6 months for preexisting conditions. Already about 130,000 people are covered by this program.

Through its direct pay program, Blue Cross provides automatic coverage for all members who leave their group for any reason whatsoever.

Programs for the Retired and Veterans

Blue Cross has now developed a program for providing comprehensive group coverage at the regular rates to retired employees groups where formal retirement programs are in effect. With this program for retired employees, we have achieved something we have dreamed about for years—and that is Blue Cross comprehensive coverage from the time of birth to the grave.

Finally, through its veterans program, being handled through an agreement with the Veterans Administration, Blue Cross has demonstrated its ability to provide care to noninsurable cases that are the responsibility of the Government by making their home-town hospitals available to them the same as for all Blue Cross patients. The Government agency involved, which is the Veterans Administration in this case, simply certifies that the individual is eligible for hospitalization. He is given a choice of hospital and doctor like any other Blue Cross member. Blue Cross pays the hospital bill. The Veterans Administration reimburses Blue Cross for the costs plus a small amount allowed for overhead.

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Operating Expenses

I have dealt with Blue Cross income, with Blue Cross payments to hospitals, with Blue Cross overall enrollment and with the complex pattern of the effort Blue Cross has made to bring its protection within the reach of every possible segment of the people of Michigan. All of these facts raise a pertinent question: How much of each dollar of income has Blue Cross used to achieve these ends?

For the first 7 months of 1952, the net operating expenses of Michigan Hospital Service amounted

to 4.64 percent of the earned income. During 1951, our net operating expenses amounted to 4.90 percent of earned income, and during 1950, it was 5 percent of earned income. Blue Cross is non-profit.

Summary

To summarize: Blue Cross covers more people in Michigan than all of the other hospital prepayment programs put together. Its present large enrollment and rapid growth show that it meets what the people want. The backing it has received from its 195 participating hospitals, which account for about 90 percent of all the general hospital beds for acute illnesses in the State, shows that the hospitals regard Blue Cross as their own program. The important role Blue Cross is playing in stabilizing hospital's finances speaks for itself.

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Commissioner RUSSEL V. LEE. Mr. McNary, would it be possible for Blue Cross to take over the entire veteran load on an insurance basis, presuming the government might buy a Blue Cross policy for every veteran upon discharge?

Mr. McNARY. It might be possible. We would not be able to take over only those veterans who go to a hospital on an insurance basis.

Commissioner LEE. I mean every veteran upon discharge.

Mr. McNARY. I am quite sure that would be possible and feasible.

Commissioner LEE. Could you afford to cover them even for a long term illness such as neuropsychiatric disorders?

Mr. McNARY. There would probaby have to be a limit on the neuropsychiatric services, unless it were possible to pay the charge. The voluntary plans have not felt that the public at large was willing to pay what it cost for the long-term cases which have been accepted as a government responsibility for some time. If that were done the way you are suggesting, it would change the whole pattern in that respect. But it would be possible.

Commissioner LEE. It would be simply to eliminate the custodial type of thing and then the neuropsychiatric and cover all the rest.

Mr. McNARY. Yes. Yqu see Blue Cross today will cover a veteran for a service-connected disability without question if he goes to a Blue Cross Hospital and does not ask for veterans' care. There is no new load involved in what you suggest.

Commissioner WALTER REUTHER. Are there any figures available as to what it would cost to provide Blue Cross service to retired workers as a group—how much more that would cost than if they were factored into the total group? Are there such figures available?

Mr. McNARY. We have such figures. We are not very proud of them because they are not for a long enough period. It costs more; there is no question about it. We do have some figures on that, but they are not very good yet because we have not had any of these retired groups as such enrolled for a long enough time.

Commissioner REUTHER. We need that type of material very badly, because I think we can all agree this group of older people is increasing very rapidly—and the unfortunate part is that at just this time when they need the most medical care their incomes have been reduced and they can least afford to pay for it.

Mr. McNARY. That is why this retired program on the same basis of the group program is so appealing and so desirable. But it means the group itself has to carry that load if it is going to be done.

Commissioner LEE. Could you work it out for them to utilize nursing homes and home care, rather than hospitalization?

Mr. McNARY. It is being worked on but I do not know the answer.

Commissioner LEE. You have got no plan for that yet, no blue print?

Mr. McNARY. No.

Statement¹ by

MR. J. PHILO NELSON

Executive Director

**Hospital Service of California, Blue Cross
Oakland, Calif.**

It seems to us that the question of how prepaid medical care can best be provided is rapidly being solved by the people themselves. In the San Francisco Bay Area, prepaid health plans have grown enormously. Labor-management negotiated health plans have stimulated this growth to a point where it appears that prepaid health insurance for employed people and their families will soon be as common as the 40-hour workweek.

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

Even as far back as 21½ years ago, a sample survey conducted by the Research Council for Economic Security indicated that 85 percent of the responding firms in San Francisco stated that they had at least a prepayment hospital benefit program available to their employees.

Blue Cross has played a leading role in this area; it pioneered prepaid hospital insurance 15 years ago and today has about 520,000 members in the immediate Bay Area.

Experimentation With Coverage

It has been our experience that various segments of our population want different types of coverage, depending on economic circumstances and local conditions. We have found that protection which may fit the needs of one group or one area may not necessarily fit the needs of another group or area. Therefore, we have been willing to experiment in order to meet the demands of our subscribers.

Our hospital plan has been broadened on nine separate occasions while surgical benefits have grown from a single schedule to four different optional schedules. At the same time, we have branched into the field of medical benefits in the hospital, the home and the doctor's office.

Today, we have plans in effect which represent more than 50 separate variations in combination of benefits, developed in response to the particular needs and resulting demands of our members. And all these services are being furnished by existing facilities and practicing physicians with free choice by the subscriber.

A recent survey made among our own subscribers indicates that except for maternity care, over 90 percent of the subscribers leave the hospital with their hospital bill paid in full or with less than \$10 charged to them.

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Growth of Plans Unabated

Blue Cross has for years permitted subscribers who leave employment to continue their health benefits, notwithstanding the fact that they may be pensioned, disabled or simply retired.

Even though the past few years have seen hospital costs double, Blue Cross has kept pace and the growth of prepaid plans continues unabated. For the past several years, Blue Cross has operated on overhead expenses of within 10 percent and is currently operating at an expense figure of less than 8 percent. This has permitted a re-

turn of approximately 90 percent of our income in actual services to members.

It is not visionary to assume that before long nearly all workers will have prepaid health insurance for themselves and their family dependents. While most of this growth has come through the avenue of the so-called group principle, Blue Cross also makes available a health program for individuals and individual families.

The Indigent Problem

The one field left untouched is the indigent or semi-indigent. If public facilities prove inadequate for the care of this class of the population, there is no reason why arrangements could not be made by government and nonprofit prepaid plans whereby so-called private facilities could be used through the presentation of an identification card of the nonprofit plan, with the plan itself merely acting as the paying agent for government.

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Commissioner RUSSEL V. LEE. Did you say your overhead was between 8 and 9 percent now, Mr. Nelson?

Mr. NELSON. Currently it is slightly under 8.

Commissioner LEE. They told us in Michigan a week ago that they had it down to 4.6. How did Michigan beat you?

Mr. NELSON. Well, they are ahead of us. I don't know if it is 4.6. I was going to guess 5, but just a couple of years ago they were up above us, so perhaps we can get down there, too. They do have a substantially larger volume than we do.

Commissioner LEE. They do most of the business that is done in Michigan?

Mr. NELSON. Yes, they do.

Statement¹ of

MR. E. A. VAN STEENWYK

Executive Director

**Associated Hospital Service of Philadelphia
Philadelphia, Pa.**

The Associated Hospital Service of Philadelphia is a Blue Cross plan approved by the American Hospital Association. It was started in 1938 and was originally financed by a loan from the Community Fund of Philadelphia totaling \$30,000.

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

The loan was repaid within 1 year, with 2 percent interest, and the corporation since then has never received money from any other source than subscriber fees.

The purpose of the Blue Cross is to pay hospital bills of its 1,845,016 subscribers when they need care. It has contracts with 89 hospitals in the Philadelphia area which back up the promises it makes to its subscribers. It is a nonprofit corporation organized under special enabling legislation adopted by the Commonwealth of Pennsylvania.

Since its organization in 1938, through June 30, 1952, it has paid hospitals about \$97 million for hospital care, or 86 percent of all income from subscribers. Its total operating expense now is about 8 percent of income, so that 92 cents out of every dollar collected from subscribers is available for current or future hospitalization expenses of subscribers.

While 1,845,016 subscribers are now enrolled, during the 13 years of its operation, 1,418,044 subscribers have had their hospital bills paid for them by Blue Cross in Philadelphia for a total of 10,020,502 days of hospitalization.

Some judgment of present volume can be obtained by reporting upon the experience of the twelve months ending June 30, 1952. During these 12 months the subscribers' payments to Blue Cross totaled \$20,793,390.19. Payments by Blue Cross to hospitals for subscribers' care during the same period totaled \$19,622,840.24. Operating expenses equaled \$1,658,536.49, or 7.98 percent. During the same 12 months, \$4,487,986.54 was withdrawn from previously established reserves in order to meet all current obligations.

Blue Cross in Philadelphia is also agent for Blue Shield, the doctor's plan, which pays medical and surgical bills for subscribers. Although this arrangement under which Blue Cross represents Blue Shield is only 3 years old, by June 30, 1952, 599,046 Philadelphia Blue Cross subscribers have been enrolled in Blue Shield as well. Payments on behalf of Blue Shield subscribers to doctors 12 months ending June 30, 1952, totaled \$3,244,387.20 for the care of 58,559 subscribers.

Substantial Gains

During this same period subscriber rates have been increased for the individual from 75 cents to \$1.20, and for the family from \$2 to \$3.50, or 75 percent. More volume, better average selection, the member hospitals' understanding of the pur-

poses of Blue Cross and lower operating cost of Blue Cross have together made this kind of bargain possible for Blue Cross subscribers. During the 13 years Blue Cross has operated in Philadelphia, the average stay of Blue Cross subscribers dropped from 10.1 days to 8 days. The average hospital bill during this period nonetheless increased from \$73.74 for 10 days in 1938 to \$148.70 for 8 days in 1951, an increase of 202 percent.

The high cost of hospital care for the individual makes Blue Cross essential coverage for people of almost every income group. In 1951 the highest bill paid by Blue Cross for a subscriber hospitalized was \$4,310. While a hospital bill for this amount is unusual, at the present time hospital bills for \$500, \$1,000, and up to \$1,500 are not infrequent.

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Better Distribution

With reference to the matter of better distribution of hospitals and doctors which has been referred to several times, I would like to point out that in the areas where Blue Cross and Blue Shield are dealing with communities that have fewer doctors and hospitals, it has been found that it has not been because doctors did not want to go out into those areas to establish a practice, so much, as the fact that there were not the facilities that they were accustomed to using in the schools and colleges and in their medical training.

And so I think that an important contribution has been made toward the solution of this problem through the Hill-Burton Bill. 1,700 hospitals and health centers, as you know, have been created during the period it has been in operation, plus the extension of voluntary insurance in those areas.

We found that it is not because farmers do not have money; it is because the doctors do not want to go there so much because they do not have the facilities to provide the kind of medical care that they have been trained to provide.

Doctors and Hospitals Gain

While benefits to subscribers have so far been emphasized, doctors and hospitals also gain.

The difference in the financial situation of Philadelphia hospitals as a result of enrollment of Blue Cross may be seen in the distribution of days in Philadelphia's State-aided Blue Cross member hospitals. In 1939 only 28.4 percent of the days provided by these hospitals were in private and

semiprivate accommodations; sixty percent of the days were provided to patients on a "part-pay" and "free" basis. By 1951, 54.4 percent of the days provided by the same hospitals were in private and semiprivate accommodations and only 24 percent of the days were provided to patients on a "part-pay" and "free" basis.

It should be noted that the difference to hospital income between "part-pay" and "free" days has never been very great in Philadelphia, those paying for care on a "part-pay" basis never paying more than about 20 percent of the cost of providing the service. This has helped hospitals but it has also helped doctors, because the free load for both has been lightened.

While it is true that factors other than Blue Cross, such as higher wages, other insurance and fuller employment, must be given due consideration in explaining the difference in the situation facing hospitals and doctors, then and now, the twin facts—(1) that Blue Cross has enrolled three out of five families in the entire greater Philadelphia area; and (2) that Blue Cross subscribers, because of their contract, are entitled to semiprivate facilities—have unquestionably been of great importance in the changed situation.

Greatest Coverage

While it is difficult to estimate the number of persons covered by all types of hospital insurance in the Philadelphia area, some indication may be obtained from a survey made by the Research Council for Economic Security in May 1950. The Council found that 83½ percent of the firms reporting in Philadelphia had prepaid hospitalization plans available for employees, and that out of the companies having such coverage, 82.9 percent were covered by Blue Cross, the highest such percentage found in this survey of 12 American cities.

It is, therefore, probably a conservative estimate that 2,200,000 people are protected in varying degrees by insurance against hospital bills in the greater Philadelphia area.

Dependents Also Covered

I would like to emphasize that Blue Cross and the Blue Shield provide coverage for subscribers and their dependents as well as for the employed person.

Coverage is extended to them when employed and when out of employment, for all subscribers for as long as they live and continue their sub-

scription payment. No cancellation has ever been made because of a subscriber's health condition. The benefits are provided on a service basis, as distinguished from usual insurance which provides indemnities, so that all of the expensive services the hospital provides to the sick are made available to subscribers practically without additional expense to them.

Special Contracts for National Accounts

The flexibility of Blue Cross and Blue Shield in Philadelphia is demonstrated in their development of special contracts for national accounts.

These contracts make it possible for the employees of such firms to be provided the same level of benefits whenever they may be employed.

In addition, all subscribers are given the benefit of a reciprocity program so that subscribers of the Philadelphia plan are eligible to become subscribers of any other Blue Cross and Blue Shield plan without waiting periods or penalties when they leave Philadelphia. Subscribers of the Philadelphia plan who are hospitalized while away from home are also provided service benefits of the plan in which they are hospitalized.

The Philadelphia plan then reimburses the host plan the amount it pays its member hospitals for such care. As a consequence, a subscriber to the Philadelphia Blue Cross plan may move to New York City and be transferred to the New York plan.

Later, while visiting in Minnesota, he might be taken ill. Since he has been transferred to the New York plan, this plan will acknowledge liability to the Minnesota plan through an Inter-Plan Bank arrangement set up and operated by the plans there. Service benefits of the Minnesota plan will then be authorized to the subscriber.

The Minnesota plan will then, for the period of illness to which he is entitled, give him the rights of its service contract with its member hospitals, the New York plan reimbursing the Minnesota plan on account of its payment to its member hospital through the Inter-Plan Bank.

Development of Uniform Coverage and Benefits

I would like to mention also that Blue Cross and Blue Shield are developing coverages for national concerns which provide uniform coverage, uniform benefits for the employee wherever he may be at a uniform rate for the account—that is, for the firm itself.

At the same time I would like to say that all subscribers, whether under such uniform coverage or not, are entitled to reciprocity as between the 90 Blue Cross plans across the country. We have more than 90 percent of all the beds of all the hospitals enrolled in Blue Cross, so that a subscriber to the Philadelphia plan who is ill in San Francisco is entitled to the service control which the San Francisco Blue Cross has with its member hospitals as though he were in Philadelphia.

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Comprehensive Health Coverage

Commissioner ALBERT J. HAYES. Mr. van Steenwyk, do you know whether Blue Cross is contemplating or considering any over-all health coverage policy for either individuals or families?

Mr. VAN STEENWYK. We are beginning now. We are offering to larger industries a comprehensive coverage which is somewhat broadened from our previously offered coverage. This will provide coverage for 70 days per illness but not per year. That is, our new device is that a subscriber even under the standard contract is entitled to 30 days' care. After he is discharged from the hospital, he is eligible for a new 30 days upon the expiration of 90 days, so that it is not limited per year or even per illness. This same device is now being used for 70 days per year.

Commissioner HAYES. My question had to do with over-all health coverage, whether a person is hospitalized or not.

Mr. VAN STEENWYK. No, we are not. The problem ahead of us on that is the cost of service and organization of the service to provide it, and there are long-range problems ahead of Blue Cross before it can possibly offer that service.

Statement¹ of

MR. E. M. HERNDON

**Executive Vice President
Hospital Care Association
Raleigh, N. C.**

The Problem of Enrolling Rural People in Blue Cross

When the Medical Care Commission of North Carolina was first set up, the law provided a part in it that the Commission itself should encourage

the sale of voluntary prepayment hospitalization. The people want a comprehensive program. It is expensive. We see the value of it. We want them to have it. But in many cases, they really do not have the money, and not only don't they have the money, but there are so many other things.

Now, the hospitals, the doctors, and the general public are all interested in these people having their service in this program. It is agreed that the hospitals must be paid for their services so that they can maintain a high standard of service. It is further recognized that the payment they receive should just be slightly above cost so that they can replace worn-out equipment and keep up to date.

Admissions and Length of Stay

Physicians are in charge of ordering the admission, ordering the services while the patient is in the hospital, and determining the day of discharge. Unnecessary admissions should be discouraged. Ordering unnecessary services should be discouraged within the medical society groups, and early discharge should be encouraged.

In North Carolina, in Blue Cross, our average length of stay is less than 6 days. But the frequency of admission is very high—is around 100 and 160 persons per year per thousand members—much higher, about 15 or 20 percent or 30 percent, than the national average.

I suppose one reason for that is the fact that during the last few years, we have had more than a 50-percent illness in the available beds in general and special surgical hospitals in North Carolina. These beds are built under Hill-Burton, primarily.

Obtaining Quality Service for Rural Areas

Now, large groups of employees, mostly in cities, through the cooperation of their employers, get the best hospital services and surgical services for the least amount of money. In rural areas, you do not have that situation. You have no common employer for large masses of people. So then through some factors in rural communities, such an arrangement must be developed whereby these people, can get a good quality of service at a cheap rate. Local level interest and organization is the answer to that, and it must be of good quality. Otherwise the program will fail.

Community leaders should encourage all types of organizations to use the hospitals and their facilities and services for the health of people, and

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

it can only be done at least possible cost if proper organization exists at the lowest precinct level in every county in North Carolina.

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(The prepared statement for E. M. HERNDON, is as follows:)

Almost everyone feels that voluntary prepayment plans, most of them Blue Cross plans, offer the most effective method of financing hospital care.

Several years ago, when the North Carolina Medical Care Commission was set up, the law that created the Commission provided that it encourage the sale of nonprofit prepayment programs of hospitalization. The Committee on Financing of Hospital Care is spending more than one-half million dollars in their study, and they expect to discover a better understanding of how the instrument of prepayment can be used for all Americans. Voluntary prepayment of the cost of hospitalization is the answer, and it can be effective.

Basis of Voluntary Prepayment

The hospitals, the doctors, and the general public are all important factors.

1. It is agreed that the hospitals should be paid adequately for the services they render. These payments should be on a basis slightly above cost.

2. Physicians determine admission to and discharge from the hospital and order the services while there. Unnecessary services should not be requested. Unnecessary admissions to the hospital should be discouraged. Early discharge should be encouraged.

3. The general public wants comprehensive medical care. They must understand that it is expensive and that the lower they keep the usage, the lower Blue Cross can keep the rate, and the lower we keep the rate the higher percentage of our population we will be able to enroll.

Large groups of employees, through the co-operation of their employer, can buy the best coverage at the least possible cost. Rural families having no common employer find the problem difficult. This means that in order to extend the same coverage at approximately the same cost to persons in the rural areas, voluntary workers must do the job the employer does for the large group. This job can be done, provided the people realize that the hospital must be adequately paid to maintain efficient service, that the prepayment plan must not be abused, and that in order to get the

lowest rates rural groups must be efficiently and permanently organized and maintained, just like employer groups.

4. Community leaders should encourage organization of such groups at the local community level. Most of this is a process of educating the people. The hospitals are servants of the people. We must support them and make them work for our health.

**Statement ¹ of
DR. CARL VOHS
Vice-President
Group Hospital Service
St. Louis, Mo.**

In looking back over the past 16 years we can see how the acceptance of Blue Cross has created a desire for even broader protection against the expense of catastrophic illness. Health and welfare programs are an accepted fact in industry today. A special committee of our Board is studying a comprehensive program which will meet the full needs of these groups.

Blue Cross has helped to stabilize hospital income, relieve hospitals of credit problems and enable them to expand their facilities as well as raise the standard of living of employees.

Government can help retain the voluntary system and assure continuing improvement of the Nation's health by encouraging legislation providing payroll deduction for local, State and Federal employees, and by encouraging the States to develop intelligent programs for the care of the indigent and medically indigent.

Last year, Missouri Medical Service paid 56 percent of the total medical-surgical expense of 39,630 Missourians who used our services.

Rapid Growth in 7 Years

Missouri Medical Service, popularly known as Blue Shield, is a nonprofit medical-surgical plan sponsored by the Missouri State Medical Association. It was developed in 1945 as a companion plan to Group Hospital Service of St. Louis and serves the same area of Missouri.

The rapid growth of Blue Shield to a membership of 316,472 in 7 years testifies to the desire of the people for a program which permits them

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

to budget for medical expense and at the same time retain the private-patient-doctor relationship.

Blue Shield stresses the patient's free choice of doctor. Although more than 2,300 doctors are participating physicians and guarantee service to members, members are assured of full benefits when under the care of any licensed doctor of medicine.

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A Proud Record

We have not reached the millennium, but the doctors of Missouri and of the country as a whole are proud of the progress that has been made. Life insurance companies tell us that the death rate in recent years has been reduced drastically because of the availability of good hospital and medical care through prepayment plans.

Seven years is a very short space in which to judge a program so revolutionary as prepaid medical care. But more than 22 million Americans have expressed confidence in the ability of their doctor to help them solve the problem of meeting its cost.

And the striking thing about our typical Missouri medical care plan is that it began with local action to meet a local need. It began with a loan of \$5,000 from the Missouri State Medical Association. It has grown because it has met a need. Its annual payments for patient care to physicians are now nearly \$2,500,000.

When voluntary action can produce a record like this in so short a time, surely we may reasonably believe we have found the right way to solve the problem of the cost of medical care. Our task now is to intensify our efforts in this work that has meant so much for so many Americans. Surely this is not the time to change our direction and turn to compulsory Federal action, which, one way or another, would require physicians to be paid by the Government.

Statement¹ of

ARTHUR M. CALVIN

Executive Director

Minnesota Hospital Service Association

St. Paul, Minn.

The Blue Cross plans, of which the Minnesota Hospital Service Association was one of the

pioneering plans, for protection against cost of hospital illness have enrolled more people in less time than any voluntary program in the history of the world.

. . . Today, Blue Cross in Minnesota covers over a million, or one-third of the State's population.

During the present year, Blue Cross subscribers and their dependents are receiving over \$1,000,000 a month in hospital benefits. Through efficient operations Blue Cross has gradually reduced its operating cost to less than 7½ percent of the payment made by subscribers, thereby making available to the subscribers and their dependents 92½ cents of every dollar paid in by subscribers for present or future hospital care.

Prepayment Plan Stabilizes Hospital Income

In 1933 the American Hospital Association recognized the value of the prepayment plan principle for lightening the burdens of patients and stabilizing the income of hospitals. It is not only the size but the uncertainty of the hospital bill which makes it so burdensome for the person needing care.

Hospitals do not give service in order to get money; but they do need money in order to give service. The only question is: Who shall pay the cost of hospital care and under what circumstances shall they do so?

The American Hospital Association's approval of the prepayment plan principle has been implemented by encouragement of hospitals to cooperate with Blue Cross plans; also guidance for community leaders in developing such plans by which the people could pay their own hospital bills with their own money in their own institutions.

A set of standards has been developed by the American Hospital Association which should characterize community sponsored movements, if the hospitals are to be urged to participate in them. These standards cover such points as non-profit organizations, free choice of institution and doctor, reasonable charges to the public, adequate reimbursement of the hospitals, effective administration and control.

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Service Benefits

Blue Cross is a nonprofit enterprise, but the main advantage of Blue Cross is that it grants service benefits in contracting hospitals. In all

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

cases no additional charge is made for such hospital items as operating room, anesthetics, dressings, listed drugs, plaster casts, oxygen, laboratory services, physical and oxygen therapy, electrocardiograms, and so forth.

In some plans it provides all of the semiprivate room coverage, and in other cases there is a limitation on the amount of the room charges.

In Minnesota we are now experimenting with a new contract providing for full coverage for all necessary hospital services for each admission by a subscriber; the only payment to be made outside of benefits not covered by the contract is \$25 per admission. Blue Cross meets the needs, therefore, regardless of the size of the bill.

Statement¹ of

MR. RALPH S. SCHMITT

President

Cleveland Hospital Services Association

Cleveland, Ohio

With your permission I would like to step down for the moment from my position as president of the local Blue Cross plan and stand before you as an employer in the city of Cleveland and tell you, if I may, something of the attitude toward the Blue Cross plan which is in evidence in my own organization.

I represent a manufacturing company which employs some 1,800 people. Some 20 years ago or thereabouts, when the Blue Cross plans were started, my company too took out one of the original membership plans. As you might suppose, we have been importuned from time to time to change that membership into any one of a thousand insurance schemes and so on.

I want to say to you that this company I represent is very enthusiastic about the Blue Cross plan and what it means, not only to the management of the company but of far more importance to the employees in the factory.

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Service Contract

... Today the modern Blue Cross contract with its service provision does pay almost 100 percent. The member is not obliged to reach down into his pocket and pay out large additional sums. That is due largely because it is a service contract.

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

Now the second point I would like to make is that our people like the Blue Cross plan because the benefits in that plan have been steadily increased almost year by year until today they cover almost every possible charge that the hospital may levy against them. They do not come out with a whole string of additional bills.

Ten years ago our employees were constantly complaining to the management that their hospital bills were covered only in part by the Blue Cross plan. Today those complaints have almost completely disappeared.

When a man goes to a hospital from our factory, it is a very rare thing that he has more than a couple of incidental items to pay. Blue Cross takes care of the load in almost every instance—almost 100 percent.

Lowest Possible Cost Protection

The third reason why employees like the Blue Cross plan is that they know it is the lowest possible cost protection they can get. They know perfectly well that the administrative expense of this organization here in Cleveland amounts to less than 5 percent of the total income taken in; that 95 percent of the dollar which the employee pays into the fund gets back to him in the form of benefits, and he likes that because he does not believe that any other organization can handle a thing as efficiently as that.

Lastly, our employees like the Blue Cross plan because it is on a community level. Many of our employees know the employees in the Blue Cross offices. They are friends and acquaintances. We all work together. It is a community enterprise. The rates are determined by community experience. So it goes. It is a friendly local organization which has the support of our employees practically 100 percent.

Statement¹ of

MR. E. B. CRAWFORD

Executive Vice President

Hospital Saving Association

Blue Cross and Blue Shield programs operate in North Carolina under a special enabling act, and are designed to help solve the economics of health. We are permitted to issue legal subscriber contracts under sound regulations and adequate

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

rates so that the public can voluntarily protect itself against catastrophic, as well as normal, costs that occur when illness strikes. The corporation is managed by a board of trustees, representing equally the public, the hospitals, and the doctors of the State.

Programs Range in Coverage

Our programs vary from limited to very comprehensive services. The subscription rates vary accordingly and the public actually has a wide choice of plans. Certainly the public, to which we refer, includes our general rural population, our tenant farmers and our Negro population.

Incidentally there is no difference in rates or benefits between the program for the white and Negro population. They are exactly the same.

* * * * *

Attaining Maximum Community Coverage

It seems to me that the greatest chance for permanent solution of health problems lies in our separate communities—I am especially referring to rural communities. These are made up of individuals in many kinds of business. Illness, being inevitable sometime during a person's life, should be of concern to each individual as well as to the entire community, and naturally, the State and Federal governments.

The people in each community are actually classified as recipients of public assistance, or as those who are self-sustaining. Due to circumstances, individuals may change from one category to the other.

Those who are self-sustaining may be divided into those (1) currently ill, and (2) currently healthy. Many of the currently ill people are already protected by some prepayment program. Those not protected, that is, the self-insured, pay "out of pocket." However, the cost of illness can be so great that they may change from being self-sustaining to medical indigents. One function of Blue Cross-Blue Shield is to keep people from becoming medically indigent.

Those currently healthy, self-sustaining, have Blue Cross-Blue Shield available to them. Every such person in the State, under 65 years of age, can enroll in Blue Cross-Blue Shield in groups in their place of employment, through their "associations," or they can enroll as individuals.

* * * * *

Understanding of Prepayment Principles Vital

We want to impress upon you that an understanding of the principles of prepayment for illness—that is, what the plan can and can't do, all involving soundness—is of vital concern to all of us if we are to accomplish real results.

There are some special rate and usage problems in rural areas. Farm families are larger, which, under our flat family rate, means less income per person covered. There are dangers in special privileges such as waivers. Existing conditions seem to be more numerous. Accidents, having no compensating insurance, are more numerous. On the other hand actual admissions to a hospital for minor illness are not as high as in other type groups. These things must be understood by all of us, for they all must be considered under a prepayment program.

We see no way for Blue Cross and Blue Shield to "insure" indigents. We might be able to help if there were such a system functioning in the form of a "pooling" or "equalization" State fund. We could then assist by processing claims, clearing all types of medical statistics, et cetera, in the same way that we handle the Home Service Program for veterans having service-connected disabilities. This involves a small payment to us to offset actual expense of handling so as not to be an encroachment on Blue Cross-Blue Shield subscriber funds, and yet not for profit to us.

BLUE SHIELD

Statement¹ of

DR. O. NORRIS SMITH

Chairman

**Insurance Committee of the Medical Society
Greensboro, N. C.**

Voluntary hospital insurance must approach three goals: First, provide the subscriber with broad enough coverage to remove his worries with regard to the cost of medical care, even for prolonged illness. Please note the wording "remove his worries." I do not say repay him every dollar spent, nor do I suggest making hospitalization more attractive than return home.

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

2. Provide the hospitals and doctors with reasonable compensation, even though they should be entirely dependent upon insurance practice.

3. Make the premium level within the cost-of-living range of the average individual or family.

* * * *

Incidence of Claims

In any type of health insurance, the incidence of claims increases as the benefits become more complete. About 1935, 1 out of every 16 North Carolinians was hospitalized each year. Now, 2 Blue Cross associations were formed about that time and based their dues on an anticipated ratio of 1 claim for every 10 participants.

This claim ratio remained essentially unchanged through the war years, and has since risen to one out of every eight for simple hospital certificates. In 1948, both companies marketed a similar certificate with added indemnity benefits toward surgical expense. The claim ratio among these subscribers has been one out of five and one-half.

As originally conceived, without co-insurance protection, the Doctors' Plan, with its much more comprehensive benefits, might well have approached the claim ratio of one out of four, thus completely pricing itself out of the market.

I once called my insurance agent to ask rates on automobile collision insurance. Complete coverage under which the insurance company would pay every dollar of damage would cost more than \$250 a year. If I agreed to pay the first \$25 damages in an accident, the company would provide complete protection beyond that sum for only \$101. With \$50 deductible co-insurance, it would cost \$71, and for \$100 deductible co-insurance, it would cost only \$51.

Obviously, complete collision insurance is rarely sold, and my agent had to refer to a footnote to find the rate.

Public Ignorant of Co-insurance

The public has not yet been taught that hospital insurance costs could be greatly reduced by similar co-insurance, and only recently has it been offered such insurance with quite high—\$300 deductible—co-insurance. I hope that the public will soon be offered such insurance with \$50, \$100, and \$200 co-insurance, with marked savings in costs.

Such provisions would do away with claims from patients who are merely remaining in bed at home, or who want to get some of the benefits

to which they are entitled and who are temporarily out of work and want to economize on living expenses. The purpose of insurance is to try to protect oneself against the heavy and uncertain liabilities which misfortune brings, and not against lesser expenses which the family budget can absorb in a few weeks or months.

The best buy in health insurance will include adequate co-insurance during the first few days to curtail the rise in claim ratio, and will offer virtually complete protection thereafter for the occasional catastrophic illness lasting several months.

Broadening the Coverage Provisions

It was toward this goal of protection for the lower income families against catastrophic illness that our State Medical Society in 1947 appointed a committee under the chairmanship of Dr. B. K. Hart to effect the best possible health insurance plan for the people of this State. We wished to remove many of the exceptions and provisions which frequently exclude patients from collecting expected benefits.

We wished to include new-born infants under the benefits of the family policy, and cover the rare but high cost of congenital defects, RH blood disturbances, prematurity, and similar misfortunes. We wished to cover preexisting conditions as soon as it is feasible to protect the program financially. We wished to provide X-ray and radium therapy for malignancy. We wanted individuals to be able to receive their protection after leaving the insured group.

We wished to provide for easily performed operations in the home or office by offering identical benefits in X-ray, surgery, obstetrics, and anesthesia outside the hospital. We wished to extend hospital benefits to at least 120 days, instead of the prevailing 70-day policy. We wished to offer benefits for nonoperative medical care in hospitals.

To do all this at a price within the reach of our intended beneficiaries, we intended to introduce co-insurance comparable to automobile collision insurance.

Most of Advantages Incorporated in Plan

The Doctors' Plan incorporates all of these advantages except two. First, by edict of the Wage Stabilization Board, we cannot now sell to industrial groups more than 70-days' hospital protection. We hope that benefits will be extended to 120 days as soon as the WSB expires.

Secondly, all our efforts to introduce co-insurance on each admission have been flatly rejected by our State Hospital Association, whose members underwrite the Blue Cross loss certificate incorporated in the Doctors' Plan. For the patient entitled to service benefits who accepts semi-private accommodations, virtually the only co-insurance is 50 percent of the X-ray charge. And although this will tend to curtail a common abuse, it is insufficient to adequately reduce the claim ratio, and thereby bring the cost down to the level of prevailing insurance programs offering much less comprehensive protection. We hope that co-insurance will soon be optional with our plan.

The low income group entitled to service benefits under this certificate includes single persons with an annual income of less than \$2,400, husband and wife or widower and child with an income of less than \$3,000, and a family group including all unmarried children under the age of 18 with an income of less than \$3,600. This would include most of the industrial employees in this State up through the supervisory level. It would include the great majority of rural families whose total cash income from all sources in 1939 averaged \$2,449.

We are advised that between 70 and 80 percent of the people of North Carolina would be eligible for service benefits under the Doctors' Plan.

Overcharges in Catastrophic Illness

I should like to call to your attention to one unpublicized method whereby the cost of catastrophic illness is compounded by the current methods of hospital charges. Not only in North Carolina but generally throughout the country, hospital charges for the per diem bed rate are quoted in competition with hotel rates, and are now insufficient to cover meals, room service, ordinary nursing care, linen, and other obvious necessities.

In our State, the average ward bed is priced about \$6.50, while it costs the hospital \$9.70 per day to furnish these necessary and routine services. In order to make up this deficit of more than \$3 a day, the hospital must make a profit on extra services, especially drugs, laboratory and X-ray charges, which cost the hospital \$2.90 per day and for which the patient is charged \$6.20.

The majority of patients whose lesser illnesses require few such extras fail to pay their share of hospital overhead, while the seriously ill patient, already burdened with numerous X-ray and labo-

ratory examinations and perhaps the cost of special nursing care, is also charged 10 cents for an aspirin tablet and \$5 for a quarter's worth of penicillin.

Hospital administrators claim that the majority of the patients prefer it this way and that there is no need for change. This principle of favoring the majority at the expense of the unfortunate few is precisely the opposite to the insurance principle, whereby the majority chip in to help the few suffering greater loss. Indemnity insurance companies offering a fixed allowance toward the use of operating rooms are not concerned when the hospital raises such a fee. But Blue Cross is vitally affected by such overcharges for services which it has agreed to provide.

Statement¹ by

DONALD CASS, M. D.

President

California Physicians' Service

Los Angeles, Calif.

California Physicians' Service was organized at the time of the so-called "second depression" as a solution to the problem, especially as it involved low-income people. We had no predecessor and no precedent, and proceeded mostly by trial and error throughout the years.

Complete coverage, given at first, was an economic impossibility because of excess usage. We were able to continue in business only because our doctors carried on even when fees became so small that many did not bother to render bills.

After these formative years, I can say that the problem of providing prepaid medical care has evolved entirely into a problem of education. The growth of prepaid medical care from practically nil to over 80 million in one decade indicates the result of educational campaigns.

Complete vs. Restricted Benefits

At the present time the key to the problem is complete versus restricted benefits. Complete coverage is not only economically impossible but is unnecessary. The average claim paid by California Physicians' Service on ambulatory medical care is less than \$25, a figure far from being catastrophic economically. Adequate coverage for expensive hospital and medical and surgical care can

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

be given at a figure well within the ability of even those within low-income brackets to pay.

We recommend surgical care, including accidents, medical care while hospitalized, catastrophic coverage for those things which are really catastrophic, hospital care, and we recommend this for employed groups as well as individual family contracts.

Package Fringe Coverage

We also have package fringe coverage. That is, we, for a small additional premium, will cover ambulance costs, drugs, nursing, dental injuries, death and dismemberment, polio, and we also have had many coverages with County Boards of Supervisors, and have a plan for the care of indigent through California Physicians' Service. It is not in effect but we have a plan, and during 1949 and 1950, when several of the counties had such a large influx of population that they needed more county hospitals, we had a plan which would have obviated the necessity of county hospitals, and we could have taken care of the indigent in private hospitals at a fee for service at a less cost than building the hospitals.

Principal Unmet Health Needs

What are the principal unmet health needs in this area and what can be done to meet these needs?

We have searched the State with the aid of social agencies and through local medical associations and have found no unmet needs. As a result of paid advertising in the newspapers, we have been unable to find a single case in any California community in which adequate medical care was not available to anyone regardless of his ability to pay. This survey has been accomplished through several years of advertising in various counties of the State, namely, Alameda, Santa Clara, San Diego, Los Angeles. Bonuses have been offered through advertising, but no bona fide cases have been found in which people have been unable to obtain medical care even though unable to pay for it.

Emergency medical care has been provided in practically all counties of the State by cooperation with County Medical Societies. Doctors have volunteered to take all emergency calls when made through the County Medical Society, and we have advertised this fact through doctors' offices and through the telephone company's directories, so

that emergency medical care is also completely met in the districts throughout the State.

Providing Prepaid Medical Care

How can prepaid medical care be best provided?

Prepaid medical care can be best provided by voluntary payroll deduction on an amortization basis, through which the cost of prepaid medical care is deducted by employer or is paid in advance by individual contracts. The provision of prepaid medical care by medically sponsored Blue Shield plans, in my opinion, is the best way. This is because of the voluntary participation in the service by all doctors. By this I mean that a plan sponsored by the medical profession as a whole has the same effect on all of the doctors that a locally sponsored plan does on local doctors.

The doctors are vitally interested in the type of care provided and in the type of reaction by the public and the doctors to the care provided, so that in a medical society-sponsored plan the physicians of that society take sides and endeavor, by debate, by suggestions and by actual participation in the administration of the plan, to provide better services and to provide equitable pay for doctors. This insures that the services rendered will be rendered willingly and in the same person-to-person manner in which care is rendered to those who pay their own bills directly.

How Much Government in Medical Care?

Veterans Bureau.—Our experience in California with the Veterans Bureau has been good. We feel that ambulatory medical care is being provided veterans in California through California Physicians' Service, as an agency, in a very skillful and satisfactory manner. Veterans' care in hospitals could also be arranged through private agencies with proper contact, and it is my studied opinion that the veteran's care should be confined entirely to the care of these disabilities which arose out of his military service.

It is my opinion that veterans should not be entitled to any care in a veterans' facility for non-service-connected disabilities. In my own practical experience I have found many patients who have taken advantage of the free care at Birmingham, Long Beach, and Sawtelle Hospitals who are able financially to pay for private care without any economic burden.

Military dependents.—For military dependents in those cases in which military personnel are

situated in districts where there is no available private medical and hospital care, it must necessarily be provided by the Veterans Bureau or by the military, much in the same manner as in the pioneer days when railroad companies were responsible for providing care for the dependents of those working on the railroad in frontier districts in which no other medical facilities existed.

However, there should be no distinction because of military service. Those who are able to pay reasonable medical care fees should be cared for, preferably by prepaid medical care plans in the same manner as those not in military service. Those in military service having low incomes could have the cost of medical and hospital care amortized in the same manner that those of similar incomes can be amortized in civilian practice and cared for in private hospitals by private physicians of the patient's choice.

Hospitals.—I am completely of the opinion that hospital construction by government is unnecessary as applied to private hospitals, county hospitals, State hospitals and city hospitals. The Federal government should construct hospitals for those who are disabled because of Federal military service. The same holds true of State government in hospital construction.

I believe that the participation of tax money in privately owned hospitals, even though they are nonprofit, is a mistake. The only hospital construction entered into by States should be for those who come under the State laws as State indigents, namely, State hospitals for the insane and possibly for the chronic and the tubercular.

I would say that in cities, city hospitals should be confined to those who are necessarily confined to a hospital, such as those who are under arrest, in jails, or restraint. I believe that care of acute indigents could be given by private doctors and hospitals more cheaply and with better service than in county hospitals, and payments for the care of these indigents should be made to those rendering the service on a fee for service program.

Prolonged Illness and Care

Psychotics, tuberculous, and aged.—These people are fundamentally indigent. The tubercular person who is sick for a long time and unable to earn anything becomes indigent unless he has rich relatives. The same is true of psychotics and the aged.

This is a problem completely tied up with the care of indigents, which I believe should be properly handled by local agencies such as county homes and hospitals. This is a problem which differs from those indigents discussed above only because of the chronic and permanently indigent character of this group.

It is an open question whether the chronically ill indigents can be more satisfactorily treated and housed by public hospitals and publicly employed doctors than by private hospitals and private physicians subsidized by public funds on a fee for service basis. It is my opinion that better and cheaper care could be obtained by the latter method. I say this because I believe business operated by a public agency is always less economically performed than by private management.

Commissioner ELIZABETH S. MAGEE. Could I ask how many people you have covered by your system, and is it indemnity or service?

Dr. CASS. It is a service plan, and we have about 650,000 people covered. We had over a million people covered a couple of years ago, and the private insurance companies have increased the benefits and lowered their rates, so that I believe almost half of our original contracts are now held by private insurance companies.

The Blue Cross has had a comparable loss of membership, and we don't feel very bad about it, because the doctors as a whole agree that we would just as soon have people insured by private companies, as long as they have some kind of prepaid medical care. We feel that CPS is a monitor plan and keeps everybody else in line.

We have a service plan, and it is the only one outside of those closed panels, and we feel that service plan is the only one that doctors can offer that private companies can't, because we have the doctors.

Statement¹ of

MR. D. T. DILLER

Executive Vice President

Medical Service Association of Pennsylvania

Since 1940 the Medical Service Association of Pennsylvania has been providing a voluntary, nonprofit, prepaid medical care service to a rapidly growing number of persons working and/

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

or living in the State. The association makes payment to doctors for certain professional services rendered to members in return for their small monthly subscription payments.

Today more than 1,900,000 men, women, and children are members of the association which has been known as the Pennsylvania Blue Shield plan since 1946. Nearly 800,000 subscribers enrolled during the year ended June 30, an increase of 72 percent in 1 year, to make the Pennsylvania plan the fastest growing of 78 Blue Shield plans operating in the United States and Canada.

No Additional Charges

Operating under enabling acts of the Pennsylvania General Assembly, passed in 1939, the association has been sponsored by the doctors of the State from the beginning. Now, more than 8,282 doctors of medicine, 654 doctors of osteopathy and 428 doctors of dental surgery have agreed to make no additional charge for services to subscribers whose incomes are moderate—for example, a family subscriber whose total income is under \$4,000 a year.

More than \$26 million has been paid by the association to doctors for services provided to subscribers in nearly a half million cases of professional care. In 1951 alone 182,533 subscribers received medical surgical care for which doctors were paid \$9,542,955, which was almost as much as was paid during the entire previous 11 years, or \$10,054,234.

Through the years, as the number of subscribers has grown, it has been possible for Medical Service Association of Pennsylvania to provide additional benefits for subscribers without increasing the cost of the service. This has happened seven times, the latest increase in benefits having become effective on June 1 of this year. Low administrative cost—only 11.7 percent of income for the first 6 months of 1952—has helped to make possible such additions in benefits.

Two Types of Plans Offered

At the present, the Pennsylvania Blue Shield plan offers two types of plans to subscribers. Briefly, the benefits of the two plans providing payment to doctors for services to subscribers and enrolled dependent members of their families are as follows:

Group surgical plan.—Surgical operations and certain dental surgery in the hospital and obstet-

rical delivery in or out of the hospital. The cost of this coverage is \$2 a month for a family, regardless of the number of unmarried children under 19.

Group medical-surgical plan.—Surgical operations in the hospital, home or doctor's office; obstetrical delivery in or out of the hospital; medical care, bedside consultation, certain dental surgery and X-ray treatment for 11 specific conditions in the hospital, and home and office visits for the employed group subscriber when the illness prevents him from working. The cost of family coverage under this plan is \$3.25 a month.

Nongroup Enrollment

Blue Shield also offers nongroup enrollment four times a year to persons who are unable to join through a group. The benefits under the nongroup agreements are the same as those for subscribers enrolled in groups, except that no home and office visits are included. The cost of nongroup membership is slightly higher than for group.

Limitations in Plans

The following services are not included in any Blue Shield agreements: Diagnostic X-ray, anesthesia and laboratory services.

Plastic operations for cosmetic or beautifying purposes.

Services provided and paid for by Workmen's Compensation Laws, or which are obtainable without cost through a Federal, State, municipal or other governmental agency.

Most Blue Shield subscribers enroll in groups at their place of employment. For these there is no age limit and no physical examination is required. There also is no exclusion of benefits for known ailments or preexisting conditions.

Nongroup enrollment is limited to those under 66 years of age and in good health. No physical examination is required, but applicants must supply information concerning their health. Those with poor health records or having a chronic disease may be rejected, or accepted for membership only under a rider which eliminates payment for those conditions during the entire effective period of the agreement. All nongroup agreements require a 12-month waiting period before payment is made for conditions existing at or prior to the effective date.

Union and Management Coverage Increased

When a subscriber or enrolled family member is ill or injured, his own doctor decides what professional services are needed. The subscriber presents his Blue Shield identification card to the doctor, who reports any service for which the subscriber is eligible to Blue Shield and receives payment according to its fee schedule.

Nearly 435,000 steelworkers and members of their families were enrolled in the Pennsylvania Blue Shield plan in the third quarter of 1951 as the result of agreements concluded between a number of steel corporations and unions of the United Steelworkers of America. Membership costs in Blue Shield for employees and their dependents are paid from the welfare funds of the steel companies and the unions, to which both management and employees contribute.

The managements of a rapidly increasing number of businesses are answering the growing concern for health security for their employees by paying the cost of Blue Shield coverage for them. In such contracts, employees are encouraged to enroll members of their families, with the cost of this additional protection being paid for by the employee through payroll deduction.

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Question of Comprehensive Coverage

Commissioner ALBERT J. HAYES. Mr. Diller, would you mind answering a question. Do you know whether or not Blue Shield is contemplating now any policy which will give complete coverage to the policyholder?

Mr. DILLER. That is one of the problems which is constantly being studied, one of the objectives which we have not yet reached. That is for the future.

Commissioner HAYES. Do you have any figures from your actuaries as to the cost of a policy of that type as compared with the cost of your limited benefits now?

Mr. DILLER. We do not as yet.

Commissioner HAYES. I see. I am curious to know why you do not permit those over 65 to buy one of your limited policies.

Mr. DILLER. Nongroup enrollment is available to those that walk in off the street, as it were. There is no spread of risk as it happens. To keep the plan on a sound actuarial basis you must of

course take into consideration that those over 65 are not probably as good risks as those under 65. We are in the process of attempting to develop coverage for those over 65 years of age and remove any age limitation.

Commissioner HAYES. At best if you included those over 65 it would increase the premium, is that correct?

Mr. DILLER. That is entirely possible.

Statement¹ of

MR. CHARLES H. COGHLAN

Executive Vice President

Ohio Medical Indemnity, Inc.

Columbus, Ohio

Ohio Medical Indemnity, Inc., is the prepaid medical care plan sponsored by the medical profession of Ohio through their own professional organization, the Ohio State Medical Association, for the purpose of enabling the people of Ohio to budget against the costs of medical care.

Ohio Medical is a charter member of the Blue Shield Medical Care plans, the national association of professional sponsored medical care plans, and it is now in its seventh year of operation.

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The results of these seven years indicate that over one and a quarter million Ohioans have, on a voluntary basis, secured the protection offered by Ohio Medical Indemnity. The enrollment figure for July 31, 1952, stood at 1,310,000 members. This represented 21 percent of the total population in the area served by this Blue Shield plan.

Enrollment Basis

These members were enrolled on a number of bases. Examples:

The group plan through the employer payroll deduction.

The group plan with subscription charges being collected by a member of the group (such as United States Government employees, church groups, service clubs, and so forth).

Individual enrollment through community campaigns and other methods.

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¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

Subscriber Benefits

All benefits are of a cash indemnity nature and all payments are made directly to the subscriber to enable him to pay his doctor for the services he has received. The subscriber has free choice of physician—benefits are payable anywhere in the world.

To date, Ohio Medical has collected \$27 million in subscription charges and has paid or incurred claims in the amount of \$21 million. Since the inception of this plan in 1946, 352,000 claims have been paid, 75,000 of which have been for babies. Currently, three quarters of a million dollars each month are distributed to subscribers for medical services they have received.

The subscriber is receiving in benefits 31.93 of his premium dollar, and 11.37 cents is being used for administration. The remainder of 6.7 cents has been added to the reserves for the eventual benefit of the subscriber, inasmuch as the plan is operated on a nonprofit basis.

It is interesting to note that even with the continued growth of Ohio Medical, the plan has been able to liberalize the subscriber's contract without increasing his subscription fees. The rates for the first contract issued in 1946 are still the same today, but each year the subscriber has received increased benefits without an increase in cost to him.

Plan Encourages Family Protection

It should be specifically noted that Ohio Medical, like all Blue Shield plans, does not confine its coverage to employed individuals. On the contrary, it encourages family protection. In addition, therefore, to providing a cash benefit to the subscriber for the birth of his child, the child is automatically added to the contract without an increase in the subscription charge.

It is evident that this type of protection for the family is a long-felt need now being filled by Blue Shield, and specifically in Ohio by Ohio Medical Indemnity, inasmuch as the claim records indicate that over 65 percent of all claims occur in the female dependent and the children. In all these benefit increases, as well as in the preparation of new contracts, a constant effort is maintained to include corrective and preventive medicine.

Wherever actuarially possible, preexisting conditions are covered—in fact, many risks were assumed by action of the board of directors, and con-

centration on education was developed with the employers and their employees to insure sufficient enrollment to make the risk actuarially sound. In addition to these accomplishments, this Ohio Blue Shield plan is constantly expanding its benefits and enrollment regulations to encompass more of the people of our State.

New and More Liberal Contract

To meet the demand for a more realistic schedule of indemnities approaching present charges, Ohio Medical is now offering a new and more liberal contract. The cash payments have been adjusted to present surgical charges, and in addition will include anesthesia benefits.

In addition to this new contract, Ohio Medical is now offering a nongroup contract—one that can be sold over-the-counter to anyone—at any time. This will permit the self-employed, the farmer, and employees of groups less than five, to secure health insurance protection.

In the study stage are many other programs, including radium and deep X-ray therapy, diagnostic X-ray services, expansion of hospitalized medical illnesses, and exploration of catastrophic coverage.

It is the aim of Ohio Medical, its board of directors, and its sponsoring medical society to bring to the people of Ohio a reasonable method of budgeting for medical care on a reasonable, sound insurance basis.

Differential Payments

Commissioner ELIZABETH MAGEE. There was a statement made by the representative of the State CIO to the effect that a number of their members who had contracts—I believe through the Steelworkers Union—had such a large differential to pay for operations over and above the indemnity. I wonder whether you care to comment on that. I do not have the figures here.

Mr. COGLAN. That has occurred. We have had complaints from some of those men and others that the payment we have made has not been sufficient to pay their doctor bill. We have recognized it by conducting a survey with our subscribers and asking them point-blank the question: "What did your doctor charge you?"

From that survey we have developed a new schedule of indemnities which I mentioned in this report, and that schedule of indemnity is being

made available at the end of this week to all of our groups. It will be higher than the present schedule. Whether or not it will pay the doctor's bill is something that will have to be worked out between the patient and the doctor, but we know it is going to do a better job of paying the doctor's bill than the present contract.

It will, of course, require increased subscription charges.

Payments

Commissioner RUSSEL V. LEE. What do you pay for obstetrics?

Mr. COGHLAN. \$50.

Commissioner LEE. How about an appendectomy?

Mr. COGHLAN. \$100.

Commissioner LEE. Do you pay medical services while in the hospital?

Mr. COGHLAN. We pay \$5 for the first 2 days and \$3 for the next 28 days.

Commissioner LEE. Nothing outside the hospital?

Mr. COGHLAN. Nothing outside the hospital.

Commissioner LEE. Are the doctors content to take the indemnity payment as full payment or are they under an obligation to do that?

Mr. COGHLAN. They are under no obligation to accept payment as full payment, but we know there are thousands of cases where the doctor has accepted the payment as full payment.

The cases cited this morning, I do not know how many were cited, but we are of course prejudiced in the office when we see 14,000 claims going out every month and we know that there must be some people satisfied or we would be swamped with more complaints.

Commissioner LEE. Do you have a time limitation for your elective surgery?

Mr. COGHLAN. Elective surgery is covered immediately on the effective date of the contract.

Commissioner LEE. How about OB?

Mr. COGHLAN. Nine months.

Commissioner LEE. Are you continuing to increase the number?

Mr. COGHLAN. The number being added averages 15,000 per month.

Commissioner LEE. The plan in California is losing members every month. I wondered whether you had any such experience.

Mr. COGHLAN. No, we have not.

GROUP PLANS

A PROPOSAL FOR A NATIONAL HEALTH PROGRAM

Statement¹ submitted by

GEO W. JACOBSON

Secretary-Treasurer and General Manager

Group Health Mutual, Inc.

St. Paul, Minn.

I

Basic Conditions to Any Health Plan

Nearly 15 years of experience of our organization in the field of prepayment for medical and hospital care has pointed to certain basic conditions which must be considered fundamental in any health plan for the people of our country.

1. Prepayment is important both for the economic welfare of the individual so that serious illness will not also mean economic catastrophe, and for the improvement of service so that the individual will budget more for his service than he would otherwise do.

2. The prepayment must be geared to the income of the individual so that every family can have a reasonable standard of medical care regardless of economic status.

3. There must be control of costs. Prepayment cannot continue to do the job under conditions where the practice is to charge according to the patient's ability to pay and where the doctor and hospital regard the patient's insurance benefits as an increase in his ability to pay.

4. There must be a reasonable availability of service. Prepayment is of little or no value to the family living in an underserved area or long distances from good medical care.

5. There must be control of quality. The users of medical service need better guarantees than they now have that proper records are kept, that adequate laboratory services are used, and that the physician does not practice beyond his training and ability. In brief, good diagnosis is paramount.

6. There must be machinery for overcoming the difficulties of financing adequate services in areas of low income as well as in areas where costs are high.

¹ Submitted at the Regional Hearing in Minneapolis, Minn., September 2, 1952.

7. There should be sufficient flexibility in any program to meet varying individual and area needs, and varying degrees of public willingness to participate. The principle of growth by local choice and local responsibility, as exemplified by the Rural Electrification program, should be a cardinal feature.

II

Present Proposals and Experiments Fall Short

Most of the present proposals and experiments in the field of medical care fall far short of the objectives outlined above.

1. The indemnity plans, including the Blue Cross-Blue Shield plans, are without power to control quality or availability of service to adjust costs to income levels, or, in most instances, to control the charges made to the patients by physicians and hospitals.

2. The proposal for national health insurance fails to meet the need for encouragement and help to the local communities for the organization of services in shortage areas, either with respect to the basic services performed by the general practitioner or to the occasionally needed services of the specialist—the eye, ear, nose, and throat man, pediatrician, etc. There is some ground for the fear that national health insurance as at present proposed would even hasten the trend of physicians to the cities and would further concentrate economic control of medical services within the profession.

3. Any plan for national health insurance using the social security system would necessarily exclude large sections of the population, including many who need the protection most.

4. In both the indemnity plans and present proposals for national health insurance, the user of the service has little or nothing to say about the terms, conditions, or location of the service. This has an adverse effect upon both quality and distribution of services.

III

Obstacles Limiting Consumer Medical Care Plans

Although medical care plans sponsored by consumers have had a remarkable success in many parts of the country among both rural and urban people, their growth has been limited by a num-

ber of obstacles which the Federal government can be instrumental in overcoming.

1. The hostility of organized medicine and the tactics used by the medical societies against such plans have been a serious disadvantage in both the establishment and the operation of such plans. This hostility has deprived consumer groups of sympathetic advice and cooperation from the profession and has made it extremely difficult to get doctors to staff the plans.

2. Facilities for the practice of modern medicine are so expensive that the capital problem of such plans is a major obstacle to their organization. The average user of medical services is not in the investing class, and this is a field new and strange to the investment market, making it difficult or impossible to get outside capital.

3. The very newness of the field tends to make the margin of error in the trial and error process very large. This is further aggravated by the fact that, to a large extent, the information and research available in this field are limited to what the few existing plans have been able to develop by themselves and make available through the Cooperative Health Federation of America.

4. Like the other so-called voluntary plans, the cooperative plans are without the power to provide for a sliding scale of charges based upon the ability of the member to pay.

IV

Consumer Approach Nevertheless Offers Clear Advantages

Nevertheless, the consumer approach to this problem offers such clear advantages over other approaches in the solution of the problem that we strongly recommend it to be made basic in the development of a national health care policy.

1. With limited government assistance and participation, it can achieve the advantages of universality without compulsion.

2. It can give people in shortage areas the means for solving their own health care problems.

3. It can raise the quality of health care both by placing emphasis on conservation of health and by giving the patient group a functional interest in the standards of medical practice.

4. It can make comprehensive care, as distinguished from limited indemnity or reimbursement, available on a prepaid basis.

V

Basis of National Health Policy Advocated

In view of the above considerations, we urge a national health policy based upon the following:

1. Federal assistance to voluntary prepayment health plans to enable them to make their services generally available to all members of the community, or groups which they serve, at charges based upon the income of the members. Such aid should be available to plans meeting the following standards:

a. Nonprofit membership associations engaged exclusively in providing health care.

b. Control resting in a governing board elected by the subscriber members with at least two-thirds of the governing board being persons who do not themselves furnish health care.

c. A subscription charge based upon a fixed percentage of each subscriber's income, in return for which each subscriber family is entitled to all the services provided under the plan.

d. Open membership without discrimination as to race, creed, nationality, or economic status.

e. Compliance with established standards of health care and business efficiency.

2. Long-term Federal credit at low interest rates to finance the construction and equipment of needed facilities by the voluntary plans.

3. A supplementary plan for the entire population providing for government insurance against sickness and accident costs above a fixed amount (for example \$300), to be supported by general taxation; such plan to allow for the payment of basic health care costs directly by the subscriber or through commercial or other insurance, leaving the field open for all types of enterprise and experiment.

4. A program of Federal research, technical advice and assistance and special aids:

a. To assist the voluntary programs in meeting organizational and technical and operational problems.

b. To provide specialized help for areas of special need.

5. A program of legal aids:

a. Continued prosecution of antitrust act violations aimed at injuring the voluntary plans.

b. Provisions limiting the operation of the plan to States with laws allowing consumers to

operate such plans and engage professional personnel.

c. Provisions for payroll deduction and employer contributions for government as well as other workers.

d. Exemption of such plans from local and State taxes.

VI

Specific Provisions to Implement Program

Such a program should be implemented by the following specific provisions:

1. Federal contributions should be made directly to the qualified participating prepayment health plans. An average cost should be determined for each area, such cost to be the average amount of money necessary to provide adequate health services to each individual in the area. Each participating health plan which provided such adequate health care to its subscriber-members would be entitled to receive—as combined subscription payments and Federal contributions—an amount equal to that average cost figure, multiplied by the number of persons to whom it provides such care. The difference between that subscription income and the total sum to which the plan is entitled would be the contribution of the Federal government. Each participating plan which provided less than the standard adequate health services used in arriving at the average cost figure would charge its subscribers a smaller percentage of their incomes, and would receive correspondingly lower Federal contributions.

However, the possibility of increased Federal contributions would provide an impelling incentive to such plans to increase their benefits as soon as possible.

The relative proportion of expense to be furnished by subscriber-members on the one hand, and the Federal government on the other, should be determined after careful study, on the basis of the following principles:

a. The amount contributed by the subscriber, as a percentage of his income, should be such that on the one hand, he would not consider it too great a burden to assume, voluntarily, in return for the services he would receive, and on the other hand, he would feel a sense of direct interest in and responsibility for the success of the health care plan; and

b. The amount contributed by the Federal government should be sufficient to provide an effective incentive for widespread and immediate establishment of such plans.

c. Welfare cases should be allowed to be covered in such plans upon the payment of a reasonable, predetermined amount by the responsible agency.

The money required to be appropriated for the purpose of those Federal contributions should be raised by taxes on the general population, in proportion to ability to pay, through the regular channels of the Federal income tax.

2. Administration of Federal aid under this program should be by the Surgeon General under the Federal Security Administrator, with advice and consultation with a national health board consisting of the Surgeon General, *ex officio*, and other appointed members, selected on a nonpolitical basis for staggered terms, from among qualified persons, no one of whom shall be professionally engaged in the provision of health services.

Local administration and control of the plans themselves should be carried out through the democratically elected governing boards of the respective plans. Regional coordination and planning should also be under local control through regional health councils composed of persons representing subscriber members of the health plans in the region, and no more than one-third of the membership of such councils should be persons who are professionally engaged in the provisions of health services. All actual administration and control should be decentralized as far as practicable and consistent with the purposes of the national health program.

Any State which desired to assume responsibility for coordinating the administration of this program within its boundaries would adopt appropriate legislation and present a plan for assuming such responsibility, and provision should be made in the national legislation for the acceptance of such plans for State cooperation whenever they are consistent with the purposes of the national health program.

3. All persons not subscribing to a comprehensive medical care program within the meaning of the Federal act would be blanketed into an insurance program providing benefits to cover all costs

of sickness or accident running in excess of \$300 a year would be financed by general taxation.

Such persons would have the option of covering their basic costs by hospital and medical care insurance or by direct payment of such costs.

4. *Further recommendations.*—In order to fulfill the broad purposes of such a national program for better health care for all the people, other aspects of national health legislation should include:

a. Federal aid for the education of medical and other health personnel, with emphasis on aid to professional schools based on the increase in their student bodies;

b. Federal grants to aid in the construction of hospitals and health centers;

c. Broadening of the public health program and increased Federal aid to State public health programs;

d. Increased appropriations for medical and other related scientific research, with especial emphasis on research in the problems of child life and of old age;

e. A special program for continuing study of the health needs of the Nation directed toward recommendations for expanding and improving the national health program.

VII

Advantages of Proposed Program

Some of the advantages of the proposed program are:

1. Universal coverage.

2. Sufficient flexibility to cover such widely varying needs as those of a rural community, Nation-wide union with a welfare plan, an individual entrepreneur, etc.

3. A rapid but evolutionary growth potential which would give medical personnel and equipment a chance to expand with the growing demand; liberal Federal contributions creating incentive for people to organize to provide broad benefits; an opportunity for State participation without the necessity to wait for State action before any program can be inaugurated; financing on the basis of ability to pay; adherence to the voluntary principle; democratic control and participation on the grass-root level with emphasis on individual initiative and responsibility for the program which affects individual needs for health care.

Statement¹ of

R. O. BULLIS, M. D.

Medical Counselor

Henry J. Kaiser Company

Oakland, Calif.

I came here to draw the Commission's attention to a rather unique service plan insurance, referred to frequently here earlier in the day as the Permanente plan, which has been going in the bay area and also serves other places in California, as well as in Oregon and Washington.

The main underlying reason for the interest on the part of my employer, Henry J. Kaiser, the industrialist, is to try and help show the way, or a way, that medicine may prevent that which the preceding speaker wishes could come about: socialization of medicine.

We started 10 years ago by erecting a hospital in conjunction with one which we purchased, which was already there, by borrowing money from private sources, with the personal signatures of Mr. Kaiser and his family. Since that time we have progressed so that the last arrangements with the bank for the erection of a 230-bed hospital in San Francisco, and a like hospital in Los Angeles, was made on the record of the financial experiences of the hospital in Oakland, and was loaned by the Bank of America on the signature of the Foundation and did not need any cosigners.

There are four groups that function in this setup, and it can be copied any place. The first group is the Foundation. The Kaiser Foundation owns the facilities and in turn leases those facilities to a corporation, a nonprofit corporation, the Permanente Hospital Corporation, which runs the hospital. To the Permanente doctors group partnership, who service the various areas, this is separate in each area. The doctors rent the facilities they use for the clinics in their offices.

Permanente Health Plan

We have a Permanente Health Plan Corporation, which is a nonprofit corporation, which draws up the contracts and services those contracts, and has the arrangement with the Permanente Hospital Corporation to hospitalize the health plan member for a percentage of the health plan dollar, which I will give you in a moment. The doctor groups in the various areas also con-

tract for the taking care of the medical and surgical needs of the health plan member for their percentage of the health plan dollar.

The Health Plan Dollar

The health plan dollar is roughly divided: six and a half cents for the overhead of the Health Plan Corporation, with the balance divided equally between the hospital and the doctor groups.

The Permanente Foundation allocates the money that comes to the Foundation from the rentals of their premises toward retirement of the indebtedness on those premises, and some goes to fees for further enlargement, new facilities, and a certain percentage for charity, a certain percentage for research, and a certain percentage for education.

Payroll Deduction Plan Benefits

To give you a brief idea of the type of service that this plan gives:

The ordinary payroll-deduction plan, which takes care of some 215,000 health plan members in the State of California as of April, 1952, gives the member 111 days of hospital care without charge, for each illness or injury and for its recurrences and complications arising while a member of the plan; all services of physicians and surgeons without charge while hospitalized; all office visits at a registration fee of \$1 per visit; all necessary home calls by doctors and calls by nurses.

A charge of \$2 is made for the first home call by a doctor for each illness or injury. No charge for succeeding doctor's visits or for nurses' visits. Also, it takes care of all drugs and medicines without charge, while hospitalized, for the 111 days covered by the plan. A reasonable charge is made for drugs and medicines furnished to patients receiving treatment at their homes, or at the doctor's office.

Also, all prescribed X-rays, X-ray therapy, and laboratory tests, without charge, for each illness or injury, arising while a member of the plan; all prescribed physical therapy up to a full year's care for each illness or injury arising while a member of the plan. During the year's period, no charge is made while the member is hospitalized. Treatment received while not hospitalized will be provided at \$1 per treatment.

Additional Benefits

After a full year's care, this service will be provided at half private rates.

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

It covers full maternity care at a charge of \$60, if confinement occurs after 10 months' continuous membership; \$140 if before 10 months' membership. In the event pregnancy is interrupted or terminated, a charge will be made for services rendered. Such charges shall in no event exceed two-thirds the charge above specified for obstetrical care.

It covers all services provided at a total charge of \$15 for removal of tonsils and adenoids; physicians and surgeons, hospital care, laboratory and drugs and medicines while hospitalized.

We also provide that when a member is accidentally injured, at a point more than 30 miles from the nearest authorized medical-officer hospital, up to \$250 will be allowed for services necessary before his medical condition permits travel to the nearest medical office or hospital where health plan service is available. Such allowance will be on the basis of rates recommended by the California Medical Association for use by the Industrial Accident Commission of the State of California.

Dependent Benefits

Dependents are entitled to 30 days of hospital care, which is provided without charge, plus an additional 81 days immediately following at half private rates. All drugs and medicines are provided without charge during the 30-day period. Private rates are charged for drugs and medicines during the 81-day period.

The removal of tonsils, for instance, on the dependent, is \$35 rather than \$15. Full maternity care is provided for \$95 and \$140. The laboratory and X-rays are furnished at half the normal rate.

For this service the subscriber would pay \$3.25, for the subscriber alone; \$5.70 for the subscriber and one family dependent; and \$6.95 for the subscriber and two or more dependents.

We found that it was necessary also to offer a coverage where the dependents had exactly the same coverage as the subscriber, and for that policy it is \$3.25 for the subscriber; \$7.30 for the subscriber and one member of his family, and \$9.25 for the subscriber and two or more family dependents.

We believe that this type of care offers an example that could be copied in other areas. It is a means of giving a complete care to individuals on a very nominal fee.

Statement¹ of

DR. CHARLES A. LEE

Group Health Association

St. Louis, Mo.

The Group Health Association of St. Louis was organized in 1936—making it now 16 years old. During this period it has done some pioneer work with problems that naturally arise in connection with an organization of this kind. This association has never been a large organization, the membership varying between 300 and 600, and the membership is composed chiefly of clerks, teachers, office workers, all wage earners in the metropolitan area.

What was and is the primary purpose of group health association?

Primary Purpose of Group Health

The officers and members of this association believe that the primary purpose of this association is "health conservation through preventive medicine," with emphasis upon the development of a positive health program instead of upon remedial treatment. In other words, Group Health Association favors a program that will place emphasis upon helping the individual to keep in good health instead of giving the patient only remedial treatment after he gets sick and goes to a hospital.

Service Available When Needed

Is there a fundamental difference between these two viewpoints?

Most hospital plans with which I am acquainted provide but little if any service to the individual, unless he is in a hospital, and most so-called medical plans provide assistance or help only while the individual is in the hospital.

These hospital and so-called medical plans are excellent as far as they go, but they are not a medical plan as the membership of the group health association defines the term.

What is the meaning of the term medical plan as defined by group health association?

It is a plan that makes medical service available to the individual upon a prepaid basis when he feels the need of it. It does not operate only when the individual is in the hospital. The service is available day or night, and our Association has spent considerable time in encouraging the membership to utilize their medical services.

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

A Positive Health Program

When a person applies for membership he is given a thorough medical examination, and he must be in good health in order to be accepted. Persons with health deficiencies may be accepted, but the individual must pay for medical services for such deficiencies until they are removed, in addition to his regular payments.

We have found that through systematic medical treatment that almost all deficiencies may be removed within a relatively short time. I believe the longest case we have had was a period of about 2 years. Under present conditions any medical group cannot admit everyone to membership, any more than an insurance company can accept every individual who applies.

Why are we interested in being members of group health association? Because, one, we believe in a positive health program, a program that emphasizes the preventive aspects of illness by providing us with medical services when needed, and also giving us the opportunity to budget and pay for this service in advance of the time it is rendered.

Why do we emphasize the phrase adequate medical service when needed? Because we believe that adequate medical service is the key to a positive health program.

Keeping Abreast of Medical Research

Under most conditions an individual never sees a doctor until he gets sick. Then remedial treatment is the principal service that can be rendered. We believe that good medical service, available when needed, is the most important factor in any kind of a health program.

It is also a known fact that medical science has made tremendous strides since the turn of the century, but the plan of medical practice that prevails in most cases, whereby citizens can take advantage of this increased knowledge, is practically the same as that which prevailed at the turn of the century—the plan whereby an individual contacts the doctor after he gets sick.

This plan, as I see it, might have been satisfactory a half century ago, but in the opinion of our group it does not meet the needs of today. What the people of this Nation need is a plan that will enable medical practice to keep pace with medical science and research.

Financing Group Health

How is group health financed? At this time the members of the group health association are paying dues of \$3 a month or \$36 per year. Family membership is encouraged in the following manner: The first person in the family pays \$36 per year; the second person pays \$36; and the third person pays \$24; and the fourth person pays \$24, which makes \$120 per year for medical service for a family of four or more.

For this amount the members receive, (1) health care such as annual physical examination; (2) immunizations; and (3) health education. That comes under the heading of (a).

(b) Sick care, (1) such as general practitioner; and, (2) the services of specialists in medicine and surgery.

(c) In addition, the usual laboratory tests.

(d) X-rays.

(e) Physiotherapy.

(f) And special consulting services are provided.

Prescriptions and Drugs

The members can also purchase prescriptions and drugs at the drug store at lowered prices.

It should be noted that all medical and surgical services at the center and in the hospital up to 60 days are free. There is a charge of \$3 for a day call at home and \$5 for a night call.

We found that this service charge for home calls had to be established in order to protect our Association.

At this time, and for approximately 5 years, the Group Health Association has contracted with the Labor Health Institute of St. Louis, whereby that organization provides medical service to the membership of Group Health Association.

This is a voluntary contract entered into between two organizations interested in providing better health facilities for their members, and has proven to be most satisfactory.

Nonprofit and Mutually Managed

The Group Health Association is a nonprofit organization, mutually managed. It has pioneered in the St. Louis area in solving some of the difficult problems of getting adequate medical care of a high quality without financial hardships.

Thoroughly democratic in scope, its members elect their own board of directors and govern their own organization and activities. All manage-

ment policies are administered under authority of the board of directors. The Association does not attempt to interfere with the medical staff in anything pertaining to the practice of medicine. It operates as a lay organization, controlling the necessary business affairs of the group, and cooperates to the utmost with the medical staff in all matters pertinent to both groups.

Our plan is not presented as being the plan that we should adopt for the whole Nation. It is doubtful if any one plan will meet our total needs. Any plan that is adopted must be varied in scope and must provide for great flexibility in operation.

Advantages But Not a Panacea

But on almost every point, associations such as Group Health Association offer advantages not present in other types of organizations that provide medical care. This is because cooperative medicine is deliberately aimed at the solution of as many of the economic problems of today as is possible in any one organization. However, cooperative medicine is not a panacea.

One of its problems is that in its efforts to provide the best of medical care, it places its services out of the reach of a great many people in the lower income groups, and also the unemployed. For these groups the only answer will be some other kind of health program.

Group medicine plans will appeal to any group that knows the value of health. By making good doctors available, by coordinating their activities, by doing away with fear and pain psychology, by stressing preventive medicine, and by reducing costs, adequate medical care becomes a reality for a great many people who cannot now know the meaning of the term. That is why group health association can take as its slogan: "Prevent Illness, Don't Wait for Disaster."

COMMERCIAL PLANS

Statement¹ of

MR. MURRAY D. LINCOLN

President

Farm Bureau Insurance Co.

Columbus, Ohio

The rapid extension of health insurance has been one of the most significant social developments of

last 20 years. Prepayment for medical care has become a well-established principle. . . .

What concerns me today, however, is not what we have accomplished in this field, but rather what remains to be done. We have come a long way, but somewhere we have overlooked or submerged important problems. Perhaps it is because we know that their solution would raise controversial questions or disturb long-established practices.

Moreover, in meeting specific human needs—auto injuries, for example, or the costs of polio treatments, and other limited personal risks—we have tended to develop a patchwork of solutions. Many of our present kinds of coverage overlap and are economically wasteful. There are also gaps which we have failed to cover. In other words, we have failed to consider the whole needs of the individual family.

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Retired and Dependents Not Covered

One reason for the widespread adoption of group insurance plans has been their low cost. This low cost has been possible because the plans do not, for instance, protect the retired employees, or in many cases, the dependents of workers. Sooner or later we must face this issue of low cost versus adequacy. It seems to me that we must concentrate on two of these shortcomings in our present insurance coverage.

The first is the inadequate provisions for the aged and the chronically ill. The second is the excessive duplication, the overlapping, and the gaps in the different kinds of coverages which are now issued.

Prepayment Plans for the Aged and Chronically Ill

Let us take the case of the old, first, and those disabled from cancer, heart trouble and the other kinds of chronic disease.

In both these instances, the chances are good that family income is limited, or has stopped altogether. Even if health plans would accept such persons for coverage—and almost none of them do—the individuals themselves would probably be unable to meet the monthly payments.

It has been suggested that this is logically a field for government assistance. I do not think that that is necessarily so. At the present time individual insurance policies and industrial pen-

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

sion plans provide income in later years for those who will retire. Without going into any specific plans, I nevertheless feel that we could meet the health needs of the aged and the chronically ill without resort to government. Certainly an industry which has for years written endowment and retirement policies could extend this saving principle to health. Or groups, such as unions, could encourage their membership to provide a form of health savings for their old age. I think that as a people we should be thinking about this problem. It is a challenge to our good sense and to our humanity, and it is a job that still lies ahead of us.

Prepayment Plans To Provide Complete Medical Care

The second big job that lies ahead is a better, fuller, and more comprehensive program of medical care protection. The problem of meeting the cost of medical care has a great many facets: there is the loss of income that results from accident or illness, the cost of hospitalization, of surgical care, of nursing care, of dental services, of physicians' services at home and in the office.

There is the field of preventive medicine, which involves periodic examinations of those who are not sick but apparently healthy. There is the field of rehabilitation for the disabled. There are occupational accidents and diseases. There are the losses due to auto accidents, accidents on planes and railroads, in the school, in camp and in the home.

We have, I think, attacked these problems piecemeal. There are various forms of group hospitalization, as well as surgical, medical care, and wage-loss insurance which provide a wide range of benefits for employed groups. Individuals may also buy a large variety of policies which protect against loss due to almost any kind of accident or illness.

On the other hand, many policies are limited to travel accidents of one sort or another, or to accidents occurring under special circumstances. Both group and individual policies protecting against so-called catastrophic costs of hospitalization and medical care are now available as well.

Social Insurance

Overlapping these policies to a greater or lesser extent are several categories of social insurance.

Some occupational disabilities, but by no means all, are covered by Workmen's Compensation laws. In addition, four states now require cash benefits insurance for nonoccupational temporary disability.

We also have automobile liability insurance which goes far toward meeting losses caused by insured motorists. A rapidly growing form of automobile insurance—the medical payments coverage—provides indemnity for the medical costs of the insured, his family and guests regardless of fault.

Here is the point I wish to make. This multitude of insurance coverages offers no assurance of adequate protection to the individual family. At the same time it lends itself to duplication, overlapping and waste. Judging from the testimony of insurance claims adjusters, the extent of duplication and overlapping has not been sufficiently appreciated. In addition, any patchwork encourages distortion of coverages. For example, there is a tendency to have services, which reasonably could be provided in the home or the doctor's office, performed in the hospital.

This is because the insurance policy covers only hospital service. There is also a tendency to classify hospital costs as "miscellaneous charges" rather than as part of the daily rate. In this case, the distortion arises from the policy limits on reimbursement for miscellaneous charges are less strict than the allowance for daily rates.

These difficulties would all be eliminated if we could develop a comprehensive medical service which would be fully integrated in its various aspects.

Health Cooperatives

The role of health cooperatives: As far as I have been able to observe, the best approach to this problem has been taken by local health cooperatives. Their big advantage is that they view the needs of their members as a whole. They emphasize full service—all forms of medical care, diagnostic as well as curative, in the home, the doctor's office and the hospital. Limits as to the kind or severity of the illness or the kind of service are avoided.

Where the hospital is a part of the plan, the distinction between the daily rate and miscellaneous charges—a distinction which has no meaning to the patient—is broken down. Total medical serv-

ices are tailored to the needs of the group and its ability to pay for the services. Every incentive is present to seek and find that organization of services which is most adequate and most efficient. In this respect, a large part of the answer may have been found in the group practice of medicine.

In my view, these cooperatives offer the nearest approach to a comprehensive medical service. I do not mean to say that they provide a fully integrated service—they do not. They do not, for example, provide for wage loss or for disability covered by workmen's compensation. Nor do they as yet handle the problem of those families without income. Neither do I mean to say that this approach is necessarily peculiar to cooperatives. On the contrary I believe that other organizations—industrial, insurance companies, unions—could attain the same objectives by following as closely as possible the principles employed by the cooperatives.

Failure To Emphasize People's Needs

I am neither cynical nor contemptuous of any interest in serving our people when I point to the fact that some of our medical care plans have been developed primarily to serve the providers of the services rather than the consumer. Blue Cross was developed in the thirties primarily to increase and stabilize the income of the hospitals. However, this fact goes far to explain the failure to approach the medical care problem from the standpoint of people's needs.

I am not unaware of the problems of integrated approach. Some people are afraid of the patient, lest he "overutilize" the services available to him. I think recent studies show this fear to be unwarranted. Some people fear the doctors—or, at least, the organized ones. Some fear hospital administrators. Some fear our government—even though it is still our servant, not our master. Some fear the insurance companies. I do not fear any of these because I have faith in people and in their ability to work together to solve their common problems. Human beings are made for cooperation, not for conflict. This Commission can do much to point the way toward such cooperation in the field of medical care.

Statement¹ of

MR. CHARLES D. SCOTT

Insurance Executive

Dallas, Tex.

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Budgeting Medical Bills

In considering the problem of prepaid medical care, it seems that if adequate protection can be provided for physicians' and surgical bills and hospitalization, the important need of the public will be met. Since the average family spends approximately \$10 per month for physician's and hospital care, the amount could in all probability be easily fitted into the budget of the vast majority of American families if the bills occurred regularly each month or even each year.

The problem, however, is that such expenses are never evenly distributed as to time. A family may go for 5 to 10 years without incurring a single medical bill and then in 1 year have losses that would make up for all the good years. In addition, costs are never evenly distributed as to families. Some inevitably have more, some less. While, in theory, each family could budget for these expenses, as a matter of practice they do not and will not. Thus when unexpected hospital or doctor bills strike them, a serious, even catastrophic financial problem is generally created.

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Percentage of Voluntary Insurance Payments

According to latest figures, the total cost of hospitalization and physician service is \$4,294,000,000 per year. Even though a relatively high percentage of the population are covered by some form of health insurance, we find that only \$755,000,000, or 17½ percent, was paid by voluntary health insurance plans. Approximately 26 percent of hospital bills and 10 percent of physicians' bills were paid by insurance.

While this is not as encouraging as is desired, it is not as bad as it appears on the surface. Again, remember that there are many people who, by reason of their financial position, do not need insurance, and the other extreme, that small group that is medically as well as insurance indigent.

¹ Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

Another point to be considered is that many of the bills which go to make up the total were small in amount and caused no undue hardship on the family involved. In addition, the amount paid by the voluntary plans do not include millions of dollars paid by employers compensation or liability insurance.

What Is Being Done To Improve Situation

The insurance industry recognizes the desirability and the necessity of assuming an ever-increasing responsibility for catastrophic hospital and physicians' bills. The companies have been and are continuing to engage in the broadest kind of experimentation in order to develop an acceptable and more comprehensive coverage for these catastrophic losses. I know from the experience of my own company, as well as from a general knowledge of what others in the industry are doing, that we often embark on uncharted waters because we recognize the absolute necessity of meeting the challenge of providing adequate coverage on a voluntary plan acceptable to the American people.

Steps Taken by Insurance Companies

Specifically, the insurance companies have taken these steps:

1. Nearly all commercial companies, as well as Blue Cross organizations, have been constantly broadening their hospitalization and surgical coverages for the past 10 years. They are making larger allowances for room rate, miscellaneous hospital expenses and surgical fees, as well as other fees. The average payment per hospital entry is far larger today than it was 2 years ago.

2. A recent development in the hospitalization field is a new major expense policy being written by a number of the commercial insurance companies. Provision is made for the payment of hospital expense up to a limit of \$1,000 to \$2,000, with the first \$100 to \$200 of expense on a co-insurance basis. This coverage is being written under both individual and group policies.

3. Several years ago a company domiciled here in Texas introduced a policy providing blanket medical expense reimbursement for the treatment of polio. Today many companies are writing similar policies and have expanded the coverage

to include other specified diseases that result in catastrophic medical expense. . . .

4. Many companies are now experimenting with insurance against catastrophic medical expense, that is, insurance against complete medical care expense that would have the elements of financial catastrophe to the person involved. These, usually and properly, have a certain element of co-insurance. Most of them pay from 75 percent to 80 percent of the total medical care after a flat deduction of from \$100 to \$500. The usual limits being \$3,000 to \$5,000. While experience on this type of coverage has not been sufficient to be conclusive, the acceptance by the general public has been promising and offers considerable hope.

5. In the field of individual coverages where selection by the company is required, it has been recognized that there is a need of providing protection for the impaired risk. In the past few years, there has been a movement within the insurance industry by experimentation to gather the statistics necessary to insure these impaired risks without limitations as to preexisting conditions. The continuation of this experiment will in all probability answer one of the problems that exist in making voluntary premedical care insurance available to all of the people.

6. With this background of expansion of coverage has come the companies' obligation to reacquaint early participants in health insurance with the need for upward adjustments in protection to meet present day costs. Companies have recognized this responsibility and have made a concentrated effort to revise these coverages in light of the new benefits available, either by additional supplementary benefits or replacement with the new plans.

Sound Approach of Voluntary Insurance Confirmed

The very fact that health insurance as offered by the carriers is in free competition is assurance that the companies will strive for economy of operation and introduction of new plans acceptable to the public. There is further assurance that through the individual's right to select his own plan and company, the danger of regimentation of doctors and hospitals, as well as the patient, is eliminated. Progress in science will be fostered and advanced, and any tendencies toward rigidities in the progress of medicine prevented.

Statement¹ of

MR. R. J. JONES

Pilot Life Insurance Co.

Greensboro, N. C.

I came here as a listener rather than a speaker. I have only a few comments to make. I wanted to comment chiefly on a statement that Commissioner Cheek made. He said that the insurance companies must know what their risk is. Mr. Davis pointed out the high incidence of hospital confinement in this State.

That point right there is one that we sincerely hope that this Commission's study will put some light on. The companies at this time have a tremendous job in reappraising their rate structure in this matter of abuse of hospital finances, and the erratic charges that we run into on medical care make it very hard for us to determine just what we should set as a rate for this company.

We certainly hope that out of this study, a plan for less erratic variation of hospital costs for similar services in different hospitals can be found which will lead to more control, that will lead to better determination of who is hospitalized, and to some control over the rural cost problem, which will enable us to do the job better of extending coverage to other groups.

Right now my company has been asked to consider underwriting a plan on 12,000 employees of one employer. We know that 3 years ago one underwriter lost \$250,000 on that group. The next year, another underwriter lost \$150,000. This past year, we believe there was a loss of some \$50,000 or \$60,000. Each time there was an adjustment in rate there, but no one seems to be able to keep up with just what is going on, who is hospitalized and why. I think that this study should assist considerably in solving situations of this type, or at least we hope it will, and thereby enable us to improve our coverage of people in the State and the Nation.

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

GENERAL DISCUSSION

Statement¹ of

MR. WALDO CHEEK

State Insurance Commissioner

Raleigh, N. C.

* * * * *

Insurance can be nothing more than a service for spreading risks, and unless you have more policy holders during a given period of time than you have claimants, the rates would become so high as to exceed for each claimant the amount of his claim. His premium would amount to more than his claim, because you have to have a certain amount in there to pay the expenses of the plan. Therefore, he would drop out of the plan, and it would end.

This problem is met by drawing into the plan a constant flow of new policyholders from whom you expect no immediate claims to counterbalance those in the group from whom you do expect to receive claims. This problem of higher and higher rates as the group becomes older is also met in the case of the true group writings by the contribution of a part of the premium by the employer. The amount of this contribution may be expected to become larger each year unless the employer can bring a constant flow of new employees into the plan.

Now, with that much background, when we turn to the need for more hospital and medical insurance by thousands of our citizens who are not employed by a common employer, we are immediately faced with two important questions:

(1) Who is going to make the contribution to keep the premium on a given level?

(2) Who is going to see that there is maintained a constant flow of new policyholders from whom no immediate claims are expected?

Point of Breakdown in Insurance

If you do not have the contribution of a part of the premium, you must have more and more new

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

policyholders who may be expected to have few or no claims for a reasonable period. Here is where the individual contract or the community or association group begins to break up. Why should these young people who expect no immediate claims enter and pay a high premium just to enable a plan to pay the claims of those who are older, and, therefore, producing the claims?

It is at this point where we, who are anxious to meet this problem on a voluntary plan—or in the so-called American way—meet our most serious problem. It becomes a selling job just like the job which the fire insurance industry accomplished years ago.

I think that the job that we need to do is, first of all, to decide for ourselves just what this insurance is and see if we really know what it is, and if our attitude toward it is proper, so that we, then, can educate the public as to what this insurance is. Yet, how many of you have ever in your lifetime had a serious fire at your home or place of business? Yet, how many of you would go to bed tonight without adequate fire insurance on all of your property subject to the hazard of fire. Few of you, I am sure, because you and all the rest of our people have been sold on the value of fire insurance. We buy it, not because we expect a fire next week, but because we believe that sometime in our lifetime we might have a fire.

Annually all the fire losses in the State of North Carolina are assessed against all the North Carolina holders of fire insurance policies each year by the fire rate-making procedures. We take all the losses produced in this State, add a like amount of money for the expenses, and assess that amount of money against the people of this State the next year, and that is what they pay for the fire insurance which they buy in the succeeding year. And we have to begin thinking in terms of accident, health, and hospitalization insurance in the same way.

Reason for Success of Fire Insurance

What were some of the developments which entered into this job of selling you on fire insurance? First of all, we have a standard policy which means that you know what your coverage is when you pay your premiums, and it means the same after the fire as it did when you bought it. Can we say as much for the average accident and health contracts today?

Secondly, you have everyone who deals in property helping in the sale of fire insurance. The mortgagee not only recommends it, he requires it under the terms of his loan agreement. And yet the sentiment in this State is such that the last legislature of this State was asked by several to outlaw the sale of accident and health insurance when it is sold in connection with loans. That is just the opposite attitude. I suppose the hospitals are still being criticized because they ask you if you have hospital insurance when you are admitted. Why do we have this attitude on the part of the public?

Merits of Health Insurance Unappreciated

Accident and health insurance, as you have heard many people say who have talked before you, is still young, and during its youth we have allowed the public to regard it as something you should not buy unless you know you are going to have a claim in the near future. Why I have purchased fire insurance for 13 years, expect to purchase it as long as I own property, and I hope I never collect on a policy I ever own because I don't want a fire.

Why then do we feel cheated if we carry a hospital policy a year or so and do not collect at least as much out of it as we paid in premiums? It is because those of us who could have done a good job educating the public as to just what this thing is, have done a very poor job.

We have done this bad job because we are divided in our outlook, in our efforts and in our approach. In fact, instead of educating the public to the merits of this type of insurance, we have, in my opinion, caused them to have their present attitude toward it. Too many agents trying to sell health insurance spend more time running down the coverage of some other company than they spend explaining the virtues of their own policy. Too many physicians spend more time criticizing the present insurance policies than in trying to educate the public to its advantages.

During the past 3 years, we in the North Carolina Department of Insurance have given considerable thought to this problem. We have held a number of conferences with groups of representatives of insurance companies, hospital service organizations, physicians, and hospitals.

Joint Plan of Action Necessary

From all that we have learned of the problem involved and the difficulties to be worked out be-

fore complete medical care can be provided on a voluntary plan, we are convinced that the job will never be done properly until we can have, either on a State-wide or better still a Nation-wide level, the physicians, the hospital officials, and the insurance or medical and hospital service organizations come together to work out a plan of action to which each group will strictly adhere.

Now, I know this is the approach we are not taking, or think we are, but I would offer an additional suggestion—a plan for setting up the mechanics for enforcing strict adherence and do so with a minimum of legislation. It might be done by representatives of those three groups preparing and adopting a set of rules to be voluntarily accepted and enforced by the individual organization or agency which presently governs each group. In North Carolina these rules or this code of ethics could be made effective with respect to insurance companies and medical or hospital care organizations by the Department of Insurance, to hospitals by Medical Care Commission, and to policyholders by the Medical Society.

Necessity for Basic Rules

This is the heart of my speech. It may cause some to think that I am a little radical, but I have spent 3 years on it. I have talked to doctors, I have talked to hospital organizations, and I have talked to all groups, and you can have the President's Commission go all over the Nation and study this problem, and under the present procedure get nowhere, in my opinion, until you get to the point where you are willing to do this.

Whenever you get rules to follow and a thorough understanding that a violation of the rules will subject an insurance agent, an insurance company, a hospital or a physician to the cancellation of his or its license, you will begin to make progress. In my opinion you won't get very far until you are willing to do this.

At present the insurance companies are afraid to rely on the hospitals or the physician. The physicians and hospitals are skeptical of the insurance companies, and the public is becoming more and more skeptical of insurance companies, hospitals and physicians.

It will take the fullest cooperation of all these to do the job. Such cooperation can come only after there has been created an organizational structure which represents all three, with rules of ethics fair to each and designed to promote trust and confidence among the three groups.

Hospital Rate Regulation May Be Necessary

To do the job may require the regulation of the rates which hospitals charge for their services, or at least some fixing of the rates to be charged by hospitals for a given period so that insurance rates may in turn be fixed in relation to such hospital rates. If we are to offer anything approximating complete protection, we must know in advance what the costs are going to be.

The thing that causes so many people to fail to buy is buying a policy which they think will not cover the bill. They go to the hospital and find that the bill is twice what the policy provides, and then they just lose confidence in the whole idea of insurance.

But if we could all sit down and decide for a period of 6 months, 3 months, or a year, that hospital charges would be a certain amount, insurance companies and Blue Cross groups could then make their rates based on those hospital charges, and we could sell the public complete coverage, and when they went to the hospital, they would do the job. But we must know what the costs are before we know what kind of coverage to provide or what kind of rates to charge for the coverage.

Incidentally, since I have suggested the regulation of hospital rates, I might state that the regulation of the insurance business which has existed in this country for more than 100 years is based upon the idea of not keeping the insurance company from charging the public too much, but to see that the insurance company gets enough money to remain solvent to pay its claims when a claim comes in; and the job that we have in regulating the rates is not to keep the companies from charging too much, but to see that the companies do not charge too little in order to get business competitive-wise and then wind up in a precarious financial position when their claims come due.

So it is not derogatory of hospitals to say that their rates should be regulated. It perhaps is the only means of survival, now that we have so many hospitals in the States.

Conference To Develop Code of Ethics

Above all we are going to need an informed public; and we will need the combined efforts of hospital administrators and their staff, all of the physicians and all of us in the insurance business to do this job properly. Let's quit our bickering. Let us quit our criticizing of each other and unite

to meet the health needs of America in the American way.

May I suggest that this committee consider the feasibility of a conference on a national level to be attended by representatives of the insurance companies and agents, the hospitals and the physicians to prepare a code of ethics for all of us to follow in educating the public on this problem and in cooperating with the public in meeting this problem on a voluntary basis.

Statement¹ by

EMILY H. HUNTINGTON, Ph. D.

Chairman

**Heller Committee, University of California
Berkeley, Calif.**

* * * * *

If we are talking about the mechanics of medical care, it seems to me that the first thing that we have to look at is the economic situation about population as a whole. Here I refer to figures published by the United States Bureau of the Census for the year 1950. If we look at the distribution of incomes for the population as a whole throughout the United States, we find that half the families of two or more throughout the United States in 1950 received income of less than \$3,600. That is the urban family. Half of the rural families received incomes of less than \$2,000.

If we look at our own area here in San Francisco, we come to a little higher figure. Half of our families received incomes of less than \$3,800. However, perhaps we should look a little higher up in the income scale and say to ourselves: "What proportion of the families earned less than \$5,000?" This figure is about three-fourths of the urban families throughout the country. About 90 percent of the rural families over the Nation earned less than that, and about 70 percent of the rural families in California.

A Cushion for Nonexpected Emergencies

Now, what do these figures mean? Let us ask ourselves at what income level can a family's income be considered as adequate to allow a cushion for nonexpected emergencies?

In October of 1951 the United States Department of Labor Bureau of Labor Statistics published the most recent figures available on the cost

of a modest but adequate level of living for four-person families. These figures, of course, are varied in various parts of the United States from about \$3,800 in New Orleans, for example, to a little over \$4,000 in Washington, D. C., and about \$4,000 in the San Francisco area.

In this budget are included, of course, some allowances for medical care. For example, in some of these budgets, the sum is about \$175. In others it is about \$250, depending upon the costs of these items in the various areas of the United States.

In general, we can say that these sums which I have given you are somewhere around an income of \$4,000 and allow somewhere between 4 and 6 percent of this income for medical care.

These budgets—these \$4,000 amounts that I am giving you—are not a luxury allowance. They do not allow any considerable sums for a cushion against unexpected emergencies. They do, however, allow a sum somewhere between \$175, let's say, and \$250, to take care of possible medical bills.

Let us ask ourselves what other evidence there is as to expenditures for medical care, using the United States Department of Commerce figures, again for the year 1950. We find that medical expenditures throughout the United States average around 4 percent.

Cost of Medical Care Study

The study to which your chairman referred . . . is a study which I made covering the period 1947 and 1948. It is entitled, "The Cost of Medical Care," and I should like to place this study in evidence, if I may.

This study was of 455 persons, in various industrial occupations. They were milk-wagon drivers, grocery clerks, and painters. Their families spent an average of 7½ percent of their income on medical care. Their income was about \$4,100. Therefore, they spent an average of about \$300.

Perhaps this group of families spent more than other groups of families in our community. I cannot be sure of that. Perhaps if we had other studies they would show that California people do spend a somewhat higher proportion of their incomes for medical care. I cannot be sure of that.

The Income Barrier in Medical Bills

Now, it seems to me evident that families with incomes of less than \$4,000 or \$5,000 a year cannot,

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

without serious effect upon a modest but comfortable standard of living, pay medical bills which may amount to far larger sums than 4 or 5 percent, or the 7½ percent which I just mentioned.

Now let us ask ourselves what proportion of the population falls below the level of \$4,000 to \$5,000. If we take certain conservative estimates here, we find that half of the urban population, as I mentioned before, have less than \$3,600. Two-thirds of the rural families have less than \$3,000.

On the other hand, if we look a little further and say to ourselves, "Well, possibly families even with an income up to \$5,000 may find it difficult to pay excessively large medical bills"; if this is true, then we find that 70 percent of the urban families and about 90 percent of the rural families have incomes of less than this amount.

Now, it has been suggested by some that families—the individual families, except those in the very low-income groups—could, if they wished, budget in advance, as somebody cited a little earlier this afternoon about people cutting out certain types of expenditures. Well, if, perhaps, people cut out all their cigarettes and all their recreation, and a few other items, undoubtedly they would have a little more to spend on medical care. I think that is an unrealistic approach, however.

Who To Say How Much

If we said that families might set aside a certain sum for their medical care—let us say they would make necessary economies and try to set aside a certain sum—how much, as individuals, would they set aside? Could you, or I, or anyone else tell them how much to set aside? Somebody could look at these figures and say: "All right, put aside 4 or 5 percent, or perhaps a little more, if you fall into a group that may have a somewhat higher rate of illness," and so on.

However, this 4 or 5 percent, or even 7 percent, is an average. This average is a mythical figure from the point of view of any individual. Not any one of us can possibly know in advance whether our medical bill this year will be \$100 or \$200, \$500, or over \$1,000.

Inequality of Medical Care Distribution

Let me refer for just a moment to the study of these 455 families, to give you some of the most

recent evidence on the inequality of distribution. Let us call it the inequality of distribution of medical care.

Remember that these families had incomes of \$4,100, a little over \$4,000. They spent an average of 7½ percent, which includes medical and dental and hospital and all other types of care which are ordinarily included under that title.

However, this average does not give us a very good picture of this group of our population, because the actual range of expenditures of these families was from the few families which said they spent nothing, not even a box of aspirin—I am wondering whether there weren't some expenditures there, but a few families said: "We were healthy, we spent nothing"—on up to families who spent as much as \$2,600.

Now if you look at it percentage-wise, you will likewise see that these families spent from zero percentage, if they spent nothing, up to two-thirds of their income in this particular year for medical expenditures. A considerable number of them spent small sums; 45 percent of them spent less than 5 percent of their incomes. Twenty percent spent from 10 to 20 percent of their incomes, and 5 percent spent more than 20 percent of their incomes. I can give you the dollar figures, but I think that is not necessary.

Individual Budgeting Impossible

Now, all of these figures that I have given you, plus the earlier studies of the Committee on Costs of Medical Care, and various other studies, simply reiterate over and over again what seems to me must by now be a common and well-known fact: that no one individual can tell in advance how much he should put aside, as an individual, to take care of medical expenditures. Various methods have been suggested to try to distribute these costs. I think it has been recognized that, by and large, people in the United States, as well as in other countries, would prefer to make their own arrangements to pay their medical costs.

It has been said a number of times today that all persons in our population get adequate medical care. I have no specific evidence on the adequacy of the medical care that they receive, although there are some earlier studies which have shown that there is some doubt about the adequacy. But we do know that the medical associations have

set up an arrangement whereby, if you or I can't afford to pay for our care, something will be done about it; but I don't know what their test is as to the amount of money we have.

Perhaps if a person with an income of \$4,000 or \$5,000 went and said he was in economic difficulties, he would get his medical care for nothing, but even if he could he might not want to. Most people are independent. They pay their own costs along the way, and they want to make some provision for their extremely uncertain expenditures, which may not fall upon them at all, or which may fall upon them to a significant degree.

Development of Voluntary Health Insurance

The main development in this country in the past few decades in the health area has been in the field of voluntary health insurance. These voluntary plans have done a fine job for many segments of the population and in many other respects. It is difficult to give the exact figures as to the proportion of our population which is covered by these plans. The most recent figures I have are for 1950.

I have some later evidence which indicates that the proportion covered in 1951 and 1952 is a little higher than in 1950. However, I had to make rounded estimates, so I think I shall use the 1950 figures, and then you can simply add a little bit more, and say that these are a slight underestimate.

In 1950, 50 percent of the population had no protection. My estimate now is that somewhere around 44 or 45 percent, probably, have no protection. In other words, probably now it is somewhat more than 50 percent who have such protection.

Kind of Protection Obtained

What kind of protection do these people have? I am, again, using the 1950 figures, and each of these could, perhaps, be raised a little bit. About 15 percent have hospital protection only. A little over 20 percent have hospital and surgical. Eleven percent have hospital, surgical and limited medical care, and only 3 percent had comprehensive coverage.

Now, comprehensive coverage means that those covered have care while they are in the hospital or at home.

The question as to whether this type of coverage can be extended to large groups of our population is one about which I think there is considerable doubt. I have some figures here giving evidence as to the cost of these plans, and it is perfectly evident that these plans cost considerably more than a general public health insurance plan would cost.

There are a variety of reasons for this. I will mention just one or two of them. Some of these plans, I think, will not cover everyone in society. These plans require membership in a group. Many plans allow individuals to come in, but they must take a physical examination. These policies are relatively high in cost for low-income groups.

Full Coverage With Voluntary Plans Unlikely

In my opinion these facts, among others, make it unlikely that the volunteer medical plans will ever cover a very large proportion of the population.

In my opinion, the only way that this coverage can be extended to cover the large portion of the population who need it is through some method of social government health insurance. We have accepted social government insurance in the field of unemployment insurance and in the field of old-age insurance. I cannot see any reason why we can't accept it here.

When I speak of public health insurance as meeting this need, I think I should mention that there are certain very important principles which must be adopted if we are going to have compulsory health insurance; many people misunderstand these principles.

Important Principles

There should be comprehensive coverage of the population. There would have to be a compulsory contribution, which would be up to 3 or 4½ percent of the income.

The administration should be by State and local administrations under general Federal standards.

There should be free choice of physicians and hospitals. There should be adequate payment for the medical personnel who provide the service, and the plan should provide for medical care by the doctor in the home and in the hospital.

The plan should provide for various ancillary services in the hospital and, certainly, any system of this sort should include a provision for research and medical education as well as taking care of other problems.

DR. WINGATE JOHNSON

**Bowman Gray School of Medicine
Winston-Salem, N. C.**

I simply do not feel that I can let go by, without a little challenge, the statement of the representative of the CIO from Georgia to the effect that the National Health Insurance Act would be the answer to our medical care problems.

First of all, I would like to challenge his statement that it would insure free choice of physicians and insure the physicians free choice of patients. That is true only in a very limited sense. Patients would have a choice of physicians only if the physicians would agree to sign up with the scheme; and, vice versa, the patient would have free choice of a physician, who is not in the scheme, only if he pays the physician in addition to paying the tax that he would have to pay for his insurance.

The cost of such program, as shown in the experience of Great Britain, would be far more than was originally anticipated. It cost nearly twice as much as originally was estimated.

Federal Administration Criticized

Another thing to think about is that I have read every act that has been introduced in Congress so far to set up such a national health scheme, and as yet I do not recall any provision made for the indigents. It is simply a compulsory insurance plan. It simply forces workers, those who would be able to carry insurance anyhow, to take out insurance against health. And, then, the Government administers it instead of a private agency.

It has been shown a good many times that the government does not do things on an economical basis. During the First World War, it may be recalled that the government took over the railroads from the hands of the private owners, and raised freight rates 110 percent and ran in the red about \$2 million a day.

In the Second World War, they left them in the hands of private owners, freight rates were not raised, and the railroads paid \$4 million a day in taxes.

Another example: A former head of our Medical Association showed in a book that he pub-

lished not long ago that, referring to government hospitals and hospital beds controlled by the government, 68 percent of the beds were in government hospitals and 22 percent in private hospitals, but that the government hospitals took care of only 39 percent of the patients and the private hospitals took care of 61 percent, although they had only 22 percent of the beds.

I will take time just to bring out one other little illustration. I had a patient some time ago who came to me with a good many digestive complaints. I took his history and made an examination, and told him that he needed some X-ray studies to find out just what was wrong with his digestive apparatus.

He said, "Doctor, I have been X-rayed."

I said, "Where?"

"In the VA hospital."

X-ray Examination Left Incompleted

I got permission from his medical officer to give me his record. In due time I got a statement from the doctor that he had had two or three tests made, and part of his X-ray examination had been made, but had not been completed, and he said that unfortunately he had left before they completed the studies.

I asked the man why he left before they finished studying. He said, "Doctor, I had been there a month, and I was tired of waiting."

I would have been ashamed to have kept that man more than 3 days in a private hospital with something for which he had spent 30 days in a government hospital.

That is an example of why the government, with 68 percent of the beds, has only 39 percent of admissions, while private hospitals take care of nearly twice as many admissions.

Mrs. BROWN. I wonder if I could not be able to ask the gentleman a few questions.

Dr. RANKIN. Would you give your name, please?

Mrs. BROWN. My name is Mrs. Marilyn Brown.

Dr. RANKIN. Will you come up here and speak?

More Complete Coverage

Mrs. BROWN. I just wanted to ask the doctor who spoke if Mr. Waldo Cheek did not say that what we needed in this program in this State was more complete coverage and lower premiums, and if a national program would not actually be a cheaper program in terms of the cost to the individual than what the present voluntary insur-

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

Objections Cited

ance programs cost the individual, and wouldn't it give him more complete coverage, such as the possibility of dental services, which have not even been mentioned, and possibly even care for mental illness, which we certainly do not have?

Dr. JOHNSON. The answer to that, based on the experience of every country that has tried government insurance, is known.

Mrs. BROWN. I had thought that the figures were something like a certain percentage of the income. I am not familiar enough with the proposed law to know about that. But I had thought that it was similar to the social security program of old age survivors' insurance which more than pays for the cost to the individuals that they are paying out to. There is a surplus going in over what is being given out in benefits. I believe that is true.

Dr. JOHNSON. It is costing somebody something. Now, it may right now pay back the individual, who collects more than he has paid into it. But in the course of time it is going to cost a great deal more. It is going to cost more and more. And our tax burden already, as you may know, is getting to be right sizable. Already, of our national income, about one-third of it goes back into taxes. And that is putting us pretty close to a socialization status.

Mrs. BROWN. Of course, the income tax is a progressive tax, whereas I believe that health insurance would be a flat rate, would it not, for everyone?

Dr. JOHNSON. That would not be fair, because it would make a man who got, say, \$3,800 a year pay no more for his health protection than a man who got \$38,000 a year.

Mrs. BROWN. That is how social security works. It is a percentage of the income.

Dr. JOHNSON. But the percentage, in the legislation introduced so far, is payable on a certain income, and a man who got more than that would not pay any more for his protection than a man who got less. So it really discriminated against the man with a smaller income.

There are other objections. I could talk for an hour on it. But the principal objection that the doctors have, besides the cost of it, is the destruction of the doctor-patient relationship, which may be sentimental and all that, but that is the key-stone of the medical practice at its best.

Dr. SMITH. Dr. Rankin, may I answer part of that question?

Dr. RANKIN. Dr. Smith.

Dr. SMITH. In England, the payroll deduction plan pays only 10 percent of the cost of the medical care. The other 90 percent, or 89 percent to be exact, comes out of the other public tax funds which are collected, of course, through income tax and that sort of thing.

When the first form of this bill came up in Congress 6 or 7 years ago, Mr. Altmeyer, who was head of the Social Security Administration, testified before one of the Senate committees that in his opinion it would take a 6 percent payroll deduction plus a 6 percent equal amount from the employer. Now, that was politically unpalatable, and in the course of 2 or 3 years they got down to where they were talking about 3 percent, and the worker would pay half and the company would pay half, but then you never heard about the other 9 percent that the government was going to have to put up out of tax funds.

These things are not self-supporting. They take enormous amounts of tax money to meet the deficit.

Part IV

PROFESSIONAL EDUCATION: A VITAL PROBLEM IN PROVIDING GOOD MEDICAL CARE

Statement¹ of

DR. WILLIAM W. FRYE

Dean

Louisiana State University School of Medicine
New Orleans, La.

In the past our medical schools have been guilty of a certain amount of isolationism as far as the communities which they serve are concerned. At the present time medical educators have come to realize that their responsibilities in the field of health and medical care extend beyond the classroom, the teaching and research laboratories and the hospitals. Along with the constant progress made in the field of science, there have been constant changes in our society. New techniques have had to be devised, and must continue to be advanced, in an effort to make the many new developments in the treatment and control of disease, and the maintenance of health, available to all mankind.

Our schools of medicine must be the centers, not only for the development of scientific methods, but for developing the best possible method of applying these developments to the needs of our citizens in all communities and in all walks of life. Those responsible for developing and directing our programs of medical education are aware of these constant changes and the need for flexibility in our teaching methods.

Medical School Inadequacies

We are all aware of the many areas of community service in which our medical schools have

failed to contribute. This is due, in part, to inadequate personnel and facilities in an already crowded time schedule. In addition to teaching and research relating to the undergraduate, graduate and postgraduate programs, our staffs are responsible for the medical care of a large segment of the population in our teaching hospitals.

To secure properly trained personnel to fill academic positions and to obtain adequate financial support in our present economy are serious problems in all medical schools. These are only a few of the problems which have prevented the expansion of medical school facilities to include more community activities in their overall program.

Regardless of our inadequacies in the past, we have come to realize the importance of our medical schools in the development of all phases of health. We realize that without personnel adequately trained in preventive as well as curative medicine, our health and medical care programs will be ineffective.

Stimulation of Physician Training

In addition to the undergraduate training, leading to the degree, doctor of medicine, come the intern and residency training programs in our teaching hospitals. Many medical schools are attempting to assist the general practitioner as well as the specialist through the organization of teaching and consultant services in our rural hospitals. We are attempting to decentralize our graduate training program by assigning residents to rural hospitals. This has been a very valuable experience for our faculty members, as well as students and most important of all has stimulated young physicians to settle in these areas.

¹ Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

By arranging consultant services in the smaller hospitals from our medical school faculties, and with a planned educational program, we are able to stimulate local physicians to take a more active interest in a continuous program of postgraduate education. It is the duty of our medical schools to help the busy practicing physician keep abreast of new developments in the diagnosis, treatment, and prevention of disease.

It is hoped that in the near future more of our rural hospitals will be able to have an integrated program of teaching and research with our medical schools. Our medical schools are limited at present in the amount of cooperation they can give in areas away from the main teaching centers, due again to inadequate staffs and funds to supply these services.

Postgraduate Education

Another major responsibility of the school of medicine is postgraduate education for physicians who have completed their formal training and are established in practice. The general practitioners are looking to the schools of medicine for help in keeping themselves informed.

The main problem, in many instances, is to reach physicians in widely scattered areas, and with only a limited amount of available time. We are attempting to supply this need by means of informal conferences and consultation types of instruction and by clinical lectures in local hospitals and at medical society meetings. This type of postgraduate program helps to stimulate local groups to support the normal daily mechanism for self-education.

In addition to this type of postgraduate training it is essential that we have periods of organized study and training at our schools of medicine, in the laboratories and in the central teaching hospital. This should be a more formal type of training than can be given in the areas some distance from the medical center.

Major Responsibility of Proper Training

The major responsibility of our schools of medicine is to supply properly trained personnel to assist in the organization and maintenance of adequate health and medical care facilities. An attempt is made to develop the highest possible standards of learning and performance of which the undergraduate student, intern or practicing physician is capable.

Medical education aims to produce physicians who are not only skillful, but wise as well, in the application of the art and science of medicine. To be wise, the physician must understand the physical, psychological, and social setting in which people live. As a physician and a citizen, he must encourage and participate in efforts on the part of the community and any group of which it is composed, to improve the living, working, and health conditions of everyone.

Progress in meeting the health needs in any community will depend, to a great extent, on the character and leadership of individual physicians, interested citizens and groups. The challenge of the unsolved problems in meeting the health needs of any community must reach individuals who have the vision and ability to do something about their solution. Our program of medical education, we hope, will do that for our individual physicians.

Statement¹ of

DR. ROBERT A. MOORE

Dean

**Washington University School of Medicine
St. Louis, Mo.**

There are many aspects of the problem of health needs of the Nation which are of interest to one who sits in the dean's office of a medical school. This week, which is the first week of school this year, the problem which—although always important, and most important at the moment—is most prominent, is that of the cost of medical education.

The Commission has undoubtedly heard many significant statements on this subject, but perhaps not with quite the same viewpoint as I wish to present; namely, the cost of medical education to the student. Most of the attention in the past few years has been the cost of medical education to the medical school.

Student Costs Rise Sharply Also

The costs to the student have increased just the same as have those to the school—and to those in every part of life. The simplest and superficial approach is to compare the published statements in our catalogs for 1939 and 1952 . . . tuition and fees in 1939 were \$523; and in 1952 they

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

were \$811. Books and instruments were \$75, while in 1952 they were \$110. Room and board in 1939 was \$350 and in 1952 it was \$810.

This made a total for these three items for 1939 of \$948; and the total for the same three items for 1952 was \$1,731.

However, as anyone who has had a son or daughter in college knows, the expenses listed are only a beginning.

There are only a relatively few urban centers with medical schools, in contrast to the centers with colleges. Hence, most students must live away from home, and the first item of expense is railroad fare to and from home at least once a year, and usually twice a year—namely, for the Christmas and summer holidays.

Geographical Distribution of Students

In our school—Washington University—we have 86 freshmen, and 37 are from Missouri and Illinois; the remainder, 49 of them, are from all parts of the United States. The distribution is as follows:

... For Missouri and Illinois there are 37; for the North Central States there are 5; for the Rocky Mountain States, there are 9; for the South-eastern States there are 6; for the Pacific Coast States there are 12; for the Northeastern States there are 13; for the South Central States there are 3, and we have 1 from a foreign country.

With this distribution we can put down as a minimum an average of \$100 for travel.

Costs to Freshmen Medical Students

Now, each freshman must purchase a microscope, which today costs \$330. Thus the costs to the freshman medical student are ... tuition ... a fixed charge of \$811. ... Then there is \$100 for transportation; \$110 for books and instruments; \$330 for the microscope; \$810 for the room and board; \$60 for laundry; \$200 for clothes and uniform and \$180 for incidentals, which gives the boy at least 50 cents a day for his incidental expenses.

Now, just parenthetically, let us add together the two costs.

I have put down an estimate of the cost to medical school of \$3,500, plus \$2,601 for the cost to students. This makes a total of \$6,101. Taking off the duplication of tuition and fees in the amount of \$811, the total net cost for the first year is \$5,290.

For subsequent years it is \$330 less, because the microscope is a nonrecurring expense, and in the senior year there is an additional \$75 less because few books are required. Thus the cost of the 4 years of medical school for most of the students who live away from home are \$2,601 for the first year; \$2,271 for the second year; \$2,271 for the third year and \$2,196 for the fourth year, making a total of \$9,339 for the 4 years of medicine.

This is an average of \$2,335 a year. How many families are there in America who can afford \$2,335 a year for a son and daughter? And most families have two or three children—and very frequently two are in college at the same time.

Demand for Scholarships and Loans

Is it any wonder that the demand for scholarships and loans has increased enormously in the last few years?

In 1946-47 it was \$750, in 1947-48 it was \$1,425, in 1948-49 it was \$12,346, in 1949-50 it was \$20,275, in 1950-51 it was \$23,067, the estimate for 1951-52 is \$37,000, and the estimate for 1952-53 is \$42,000.

Now, these figures are for loans and scholarship awards by the school to deserving and promising able young men and women.

At present our annual income to meet this need is about \$20,000, or less than half. We are able for a time to give more because we have reserves accumulated during the war and in the postwar period, which will not last too many years.

To maintain the traditional American principle—that no individual with ability shall be denied an education because of economic conditions—it is clear that we must be prepared to give additional help in the form of scholarships or loans in the coming year. The GI bill of rights saved the situation in the postwar years, and society has not come forward with a substitute.

In my judgment, to be certain that no worthy individual is denied a medical education because he cannot afford it, we should have the equivalent of 40 percent of our tuition charges. In 1951-52 these charges were \$283,882, and 40 percent is \$113,553. How much of this should be in the form of scholarships and not repayable, and how much in the form of loans is a debatable point into which I shall not enter.

Indenture-Type Scholarships Questioned

However, there is a trend in the awarding of scholarships during the past decade which I wish

to question. This trend is to require some sort of service after graduation.

For example, a number of States now award scholarships in return for a promise to return to that State and practice medicine in a rural community designated by the State. I am most sympathetic to the need for medical service in rural communities, but I do not believe it should be secured by an indenture. Far more important is the utilization of the abilities of an individual for the best interests of the Nation as a whole.

Let us assume—and it has happened—that a student with such a scholarship turns out to be a brilliant investigator or teacher. He could serve his country better doing research or teaching than in practice. It is true that in most plans he can repay the money advanced with interest and discharge his obligations, but if he could do that, he would not have asked for the scholarship in the first place.

Several different plans have been advanced by the Federal government, particularly by the Armed Forces, along the same lines—a year of service in the Armed Forces for each year of scholarship. Again, the Armed Forces must have an adequate medical service, but I do not believe that this is the way to secure it.

In summary, I only wish to call your attention to a problem on which others have probably spoken—the cost of medical education to the student. Inflation has increased these costs to the point where many families cannot afford medical education without help. I believe society must include some provision for this help in the form of scholarships and loans. This help should be in unrestricted form and much of it private in the sense that it is awarded by the school.

Statement¹ of

DR. W. C. DAVISON

Dean

School of Medicine, Duke University
Durham, N. C.

There is a need for rural physicians. There is a degree of argument as to how many are needed. But if you signed daily letters such as this one, you would see what I mean:

In answer to your letter, I am sorry but I do not know of an available physician at the present time, but I have made inquiries and if I hear of anyone later, I shall communicate with you.

That is one I signed this morning before I came over.

We have a news sheet which we circulate in the Medical School which always contains at least one or more statements such as the one that follows:

Physicians wanted in our community of approximately 400 people with a population of about 4,000 in the surrounding 10-mile area. Anyone interested should communicate with Mr. J. E. Thompson, and so on.

Another thing. A letter came in Saturday from the Raritan National Community Service saying:

There are several communities in North Carolina which have Raritan Clubs that are interested in securing a doctor. I would appreciate it very much if you would provide me with the name of any intern or graduate from your Medical School who might be interested in going to small towns or rural communities.

Differentiation Between Demand and Need

The difference, I think, in this argument as to whether we need more doctors was very nicely put by Dean Brauer, of the Dental School, at a panel of the Commission in Washington 10 days ago. He said that you have to differentiate between demand and need.

Now, it is perfectly true that the individual of the rural community can be brought to a city hospital or town hospital, and probably receive as good or better care than from a physician calling at his home. But the public demand is the thing which I think we in the medical schools have to consider. The public is willing to pay for home care and wants it, both in medicine and in dentistry, and it seems to me that we have got to work out a means of getting more physicians.

Problem Acute in Rural Areas

Now, the problem is particularly acute in rural areas. Those charts which Dr. Hamilton presented showed an actual decline of rural physicians. We know from the national figures that there has been a 28-percent decline in the ratio of general practitioners to population in the last 10 years. That is probably due to the increasing difficulty of getting into medical school.

There are a great many students who want to study medicine—about 22,000 last year. There are only 7,000 places in all of the American

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

medical schools, and naturally the admission committees select the best students they can get. These are not rural students because they go to rural high schools and they come up to Davidson, Carolina, Duke, Wake Forest, and flunk freshman chemistry and sophomore physics. The admissions committee realizes that grades do not necessarily determine who will make the best physicians, but out of fairness you cannot take a man with two failures on his record and turn down somebody who has passed his subjects.

So in Duke, at the present time, we have less than 4 percent rural students.

Now, the only way, I am sure, to get country doctors is to get rural students. The studies several years ago at Tennessee showed that 70 percent of the rural students of the University of Tennessee Medical College went back into rural practice. The more recent figures in Minnesota showed 62 percent or 63 percent of the rural students at the University of Minnesota Medical School went back to rural practice.

Tutoring Program Proposed

So I think that we have to get rural students. The way I think it can be done is the same way that it was done with me—not that I am a brilliant student—but I was smashed up playing football in a country high school. My father was a country preacher on Long Island, and he could not see the pleasure of my having a year's holiday doing nothing, so he hired a Harvard man to tutor me. I have never liked Harvard men since. He assigned me 6 hours' work a day and then tutored me for 2 hours. He certainly earned his money. But the thing that he taught me was the value of hard work and intellectual discipline. So when I have a job to do, such as coming over here, for example, I do it.

This is the thing that a boy in a country school does not learn, because in a two- or three-teacher high school the teachers do not have the time to give this individual attention to the students, particularly those who are interested in going to medical school.

So I proposed some years ago to set up a tutoring program with the late Clyde Erwin. He would pick out keen rural students who wanted to study medicine and bring them up to Duke for the summer between their third and fourth year to

tutor them just as rigidly and meanly as that Harvard man did me. He would then send them back as a senior in high school and bring them back again after their senior year, before entering college. As a result of these four months of tutoring, I am perfectly certain that they could get into any medical school in the country because they were taught how to work. This is the great difficulty in modern education.

I peddled that idea to 31 foundations, including the commonwealth fund, which Professor Evans is representing here. I am very glad he came in at this particular time. Fortunately Mr. Gregg was at the Commission meeting last week, and I peddled the same idea there. It was turned down. Thirty-one public health services did the same thing. I still think it is a sound idea, but I have not been able to sell it.

Selling Urban Students on Rural Practice

The only other alternative is to try to sell the city students on the advantages of going into the country. We have set up, with the cooperation of Dr. Amos Johnson, and Dr. Street Brewer, and Dr. Bond, a preceptorial program on a voluntary basis—which was 100 percent colored last year—under which senior students spend a couple of weeks with them to get indoctrinated in some of the pleasures of living in the country.

A big stumbling block is the fact that so many of the city boys will not have country wives, because the wife determines where the man is going to go. So, whether we can make it an entrance requirement that he come in with a country wife, we do not know. The medical students will do almost anything to get to medical school nowadays.

We also have to adapt our internships to better preparation for general practice. We have had splendid cooperation from the smaller hospitals in North Carolina, and the University of North Carolina has set up an even better program to get this fundamental training in general practice, which these rural physicians need.

I have set to work very rapidly on this rural student program. We are still working on it, and I hope that eventually we can increase the program at our school and also in other medical schools, because rural students are the best source for rural physicians.

Statement¹ of

DR. GORDON SCOTT

Wayne University Medical School
Detroit, Mich.

Any comprehensive survey of the health needs of a nation must consider as one of its fundamental problems and major concerns the present educational facilities and future needs of its colleges of medicine and nursing. To this basic concern most all other problems are secondary—indeed, if the colleges of medicine and nursing have the facilities and funds for expansion, many of the problems which now seem to be grave will find their own solution.

* * * * *

In 1953 the medical college will do what it has wanted to do for many, many years, e. g., enlarge its classes so that approximately 100 students will be admitted each year.

In this effort to expand classes we have received the closest cooperation of the medical profession in Detroit and in the State of Michigan. The acquisition of this new physical plant which makes possible our expansion was in our minds, but it was the first step of an over-all program, a program designed not so much to aggrandize the university as to render the city of Detroit the service which it has a right to expect from its medical college.

Our College of Medicine has operated on a budget which has not been the lowest of any medical college in the United States, nor yet by any means, the highest. As budgets and salaries go, we have been able to maintain just about a middle ground. This sounds as if we were doing fairly well, as indeed we are. However, when we are compared with other colleges of medicine in the amount of service work which we perform for the community, we are woefully understaffed and inadequately financed.

Greater Deficits Indicated

A careful estimate of our needs to bring us to a proper operating level at this time reveals that we are now short about \$225,000 a year. When we move into our new quarters and expand our classes in 1953, we should have an additional \$135,000 a year for operating expense. By 1954,

another \$75,000 a year should be added to this, and by 1955 another \$140,000 will be essential.

In summary, by the year 1955 this College of Medicine should have made available to it not less than a half million dollars a year for salaries for staff in all categories; another \$75,000 to \$100,000 for supplies to be used in teaching and research, and an additional \$100,000 for equipment and capital expense is by no means extravagant. As we expand in facilities, that is, the capacity to train more physicians, it costs more to operate our plant. For example, a new building has been added. It must be heated, lighted, and kept in condition. The cost of plant operation will be at least \$100,000 a year.

The figures given are conservative. Most medical schools taking 100 students operate on a budget of about \$1 million. We have projected our needs in this direction. The board of education at this time is giving to the College of Medicine roughly \$830,000. By the end of 1955 we must have an additional \$770,000 if we are to operate an expanded doctor education program.

* * * * *

Building Expansion

The needed and reasonable expansion in buildings which is planned will cost about \$19 million. When we compare this with the costs of many medical centers, it is extremely modest. We feel that this will enable us to do a job of teaching, research and postgraduate instruction which is entirely in line with the hospital expansion going on in Detroit now.

* * * * *

The Goal of Education

In medical education there is but one goal—that is giving the best in educational background and in training skills to the students who are our responsibility. We concern ourselves deeply with the sociological problems which surround us. We are in contact with them day by day. We are, therefore, touched and influenced by the economic aspects of medical care. We cannot but feel that our job as medical educators could be better done if we were to be freed from some of the worries of searching for the means by which we can serve.

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¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

Basis of Financial Support

Commissioner RUSSEL V. LEE. May I ask you a question or two, before you leave? You are entirely supported by public funds. Have you an endowment as well?

Dr. SCOTT. We have no endowment.

Commissioner LEE. The public funds and tuition constitute the entire support?

Dr. SCOTT. And also private funds as gifts.

Commissioner LEE. Is there any hope for the privately endowed medical school without public support of some kind?

Dr. SCOTT. Dr. Lee, it is my conviction that there is no one agency which can any longer afford the operation of a medical school, but all agencies, Government, private, and so forth, together can afford it.

Commissioner LEE. You think no medical school can hope to exist under modern conditions without some public funds of some kind? Is that your belief?

Dr. SCOTT. Or a vast amount of private capital which is not being poured into medical education at this time.

Commissioner LEE. What do you think of such plans as the one that Davison has at Duke, or at Chicago? I know they are somewhat different. The matter of being a part paid or entirely paid clinic and supporting it that way?

Dr. SCOTT. That is one way of supporting a medical school, and perhaps it is a good one. We would not mind an opportunity of trying it.

Commissioner LEE. Do you think Wayne County would approve of it? Do those plans generally work out financially? That is a serious point. Can they be made to carry their weight that way?

Dr. SCOTT. They can reasonably well.

Commissioner LEE. The over-all deficit for private medical schools is staggering when you add up what each medical school's deficit is going to be. Any kind of scheme has to be explored and rescued.

Dr. SCOTT. You either support and rescue it or lose out on medical education.

Commissioner LEE. It has to be stopped.

Dr. SCOTT. There is no question.

Commissioner LEE. You can't afford to let the private medical schools go. You can't conceive of that?

Dr. SCOTT. It is impossible.

Commissioner LEE. We need their output.

Dr. SCOTT. We will need everyone's output.

Commissioner LEE. What would you say would be a reasonable cost per medical student per year?

Dr. SCOTT. It varies tremendously with medical schools.

Commissioner LEE. It varies from \$800 to \$8,500 in the figures we have gotten.

Dr. SCOTT. Yes. Our costs are currently about \$3,300 per year.

Commissioner LEE. Per student per year?

Dr. SCOTT. Per student per year.

Commissioner LEE. Do you charge your charity hospital into that?

Dr. SCOTT. No, sir.

Commissioner LEE. That does not include the charity hospital?

Dr. SCOTT. Were we to charge the charity hospital into the cost of that, you would not dare say what it would cost you?

Commissioner LEE. That is exclusive of charity patients. That costs you something like \$3,300 per year.

Dr. SCOTT. Yes.

Commissioner LEE. You think that you should be spending more, I take it?

Dr. SCOTT. Not necessarily more per student, but if we are going to increase our number of students, we must have funds with which to do it. We have no choice. There is no such thing as mass education in medicine. It has to be personal business.

Commissioner LEE. How many students do you graduate each year now?

Dr. SCOTT. Between 60 and 65. Our classes are carrying 70.

Commissioner LEE. If you get the nineteen million, what will you do?

Dr. SCOTT. We will go up at least to a hundred.

Commissioner LEE. Thank you.

Statement ¹ of

DR. MAURICE B. VISSCHER

Director of the Physiology Department Medical School, University of Minnesota

I am not here talking for any special interest group. I am interested primarily in what education and research facilities will have to offer the community, and what changes will have to be made in facilities for support and administration of such activities, if the community wants increased

¹ Delivered at the Regional Hearing at Minneapolis, Minn., September 2, 1952.

medical service of any sort, improved medical care, and if it wants to see currently outstanding research problems of importance to the health of the people—you and me—solved within the foreseeable future.

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You cannot, of course, have progress in medical service, or in medical science, without training personnel to carry out either the activities of medical service or the work of medical research.

It is self-evident that education and research are indispensable to the maintenance and improvement of the health care of the American people. There have been large increases in funds available for the support of education and research in medicine and allied fields within recent years. However, the increases still leave a great gap between available stable support and the needs in many respects.

It is generally believed that the State universities have fared better than the privately supported schools of medicine, dentistry, et cetera. Without challenging this belief, I should like to point out areas in which support within the State universities, as I know them, has been and is inadequate.

Post-M. D. Training

The first area to which I should like to call attention is that of post-M. D. training for the development of practicing specialists and clinical investigators. At the University of Minnesota today we have on the Twin City campus more graduate students of medicine than we have undergraduates. Counting the group of graduate students at the Mayo Foundation of the University in Rochester, Minn., there are more than twice as many graduate students as undergraduate students of medicine.

The teaching aspects of this program, as far as the Twin City campus is concerned, are operated by instructors whose time and interest are distributed between undergraduate medical education, the care of patients, research, and the medical graduate teaching program. The size of the teaching staff has not increased commensurately with the increased teaching load which resulted from the large increase in numbers of graduate students since World War II.

At present, individual graduate instructors are responsible for as many as 10 or 20 graduate stu-

dents, in addition to their other duties, which is an undesirable and unworkable situation.

Three Alternatives

We are confronted with three alternatives, namely:

1. Increased staff to provide for our graduate teaching program;
2. Curtailment of the program, or
3. Deterioration in quality of work.

Increase in staff size has not been possible. In fact, the inflation of the last few years has necessitated decreases in academic staff because salaries, especially those of nonacademic personnel, have had to be increased. Over this university as a whole a reduction of approximately 500 academic employees has occurred. In the medical sciences it has resulted in a number of instances in the transfer of academic employees from teaching to research appointments.

It seems improper for an institution such as ours to carry on a graduate teaching program utilizing to any major extent personnel appointed on short term grants for research or teaching purposes. There can be no permanence to an arrangement in which career investigators and teachers are appointed on a year-to-year basis.

It would be a conservative estimate to suggest that the addition of a half million dollars per annum to the stable continuing support funds of this medical school would be necessary in order to provide stability and continuity to the graduate teaching and research program under way at the present time.

Funds for Newer Fields

A second area in which funds are required for desirable developments is in the newer fields of medicine, and in the medical auxiliary services, especially as regards teaching in these areas.

For example, there can be little doubt of the desirability of promoting education in the field of physical medicine and rehabilitation. Likewise, the training of more technicians in physical, occupational, and psychiatric therapy seems indicated. The training of more nurses available for general duty is a perpetual problem. The development of more potential investigators, with basic science training in neurophysiology for research in the problems of neuropsychiatry seems urgent. Many other examples could be cited.

Funds for training programs and for the setting up of desirable permanent positions for quali-

fied experts are interrelated needs. For example, it is useless to suggest that one should provide facilities for training more neurophysiologists for work in fundamental aspects of neuropsychiatry unless there are prospects of permanent positions available to them when their training is completed. It is absurd to train large numbers of clinical investigators if there are not increased numbers of positions to which they can aspire with more than annual tenure.

It may be argued that the program which is suggested represents an inverted spiral with a prospect of ever-increasing cost. This is not necessarily true. The questions are, in reality:

1. How large a program of medical training and research will the American community want to pay for?

2. How large is the manpower pool of qualified persons who will want to engage in such activities for their lifetimes?

The latter is not inexhaustible, but it is definitely larger than can be supported with existing funds.

Allocation and Expenditures of Existing Support

Since the economical use of funds is at least as important as the absolute magnitude of available funds, I wish to bring up another problem which I believe to be of equal importance to the provision of larger sums of money for education and research in the health fields. It has to do with present policies and practices with regard to the allocation and expenditure of existing sources of support, particularly from the Federal agencies.

The legal limit for guaranteed support for most projects under United States Government agency subsidy in medical teaching and research is 1 year. Moral commitments, contingent upon continued appropriations, are being made for longer terms, up to 5 years.

There would seem to be no inherent reason why the Congress could not commit itself to more stable support of continuing organizations. If Federal support is to be of maximum significance in promoting education and research in the medical fields, there must be a certain fraction of funds which are at least as stable as the national economy itself.

The short term nature of existing research and teaching support is a major self-limiting factor in the effectiveness of the funds. Young scien-

tists are not encouraged to pursue scientific careers under these circumstances, and they become progressively more discouraged as years pass and stable positions do not appear for them.

Without increasing expenditures at all, great increases in results could be achieved by making a fair fraction of existing funds available for long-term projects. What is urgently needed is more men and women making careers of medical science.

A Step-wise Basis for Increased Support

Finally, I should like to recommend that in any program of increased support for education and research in the medical fields, arrangements for increased support be planned on a step-wise basis, beginning in a modest way, but looking forward to continued expansion to a level which seems to the Congress and to technical experts to represent the amount that the community can afford to pay and can be effectively and economically used in improving the health status of the Nation over a reasonable period of time.

There should, it seems, be a board of experts who would continue to evaluate the effectiveness of use of funds in individual institutions, in order that political considerations might be held to a minimum in the determination of the share of available funds placed in particular institutions. This is not to say that the established institutions should be given the lion's share, because it might be, and probably is, in the interest of the community to develop superior institutions in areas where they do not now exist.

Emphasis should be placed on the development of institutions under public and quasi-public control, because under the American principles of government tax funds should not be used for the advancement of special interest groups of any sort.

Statement ¹ of

DR. L. R. CHANDLER

Dean

Stanford School of Medicine

Stanford, Calif.

I think there are two points in the study by this Commission that should be given consideration in the contribution of medical schools to the health needs of the Nation. Medical schools serve in two

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

different ways; one directly, and one, of course, indirectly, and they are both of some importance.

Directly, the medical school's first job is to prepare personnel in the various fields of health, and I think it is well recognized that the 72 four-year medical schools in this country are doing a pretty good job.

Secondly, it is necessary to have control of patients with diseases who come to the medical school faculties and are under the care of students, either undergraduate or graduate students who serve as their doctor—the students being under direct supervision of experts—and to incorporate in it a group of well people for preventive aspects of health and the maintenance of good health. Much has been said recently about medical school faculties going into private practice in order to make money to finance the bankrupt medical schools.

University Hospital and Clinic Costs

I think it is fair to say that all universities that have decided to have university schools of medicine or colleges of medicine are perfectly willing to pay the costs of education. The lay presidents and lay boards recognize those costs of faculties and teaching equipment. I don't know any university with a medical school that is objecting to paying those costs. The financial problem is one of meeting the costs of medical care for the selected group that a faculty and its student body needs in order to train the next generation of doctors.

That is being met at the present time, as you know, in two different ways. Some of the schools do not own hospitals and are dependent upon tax-supported agencies, such as county and State hospitals, where health, hospital, and clinical costs are paid for. Others own their own hospitals, and they are meeting it by charging primarily to education their own hospital costs that are not paid for by the patients.

Thus the lay Boards of Trustees and universities have reached a point where they say, "We must look this over pretty carefully."

I am in accord with them. The problem should be surveyed, and our own school has just spent about 4 months on that very problem. I think it is fair to say that the cost of care of the selected group of patients—and I use the words "selected group," and I will elucidate that in just a minute—as not a just charge on educational budgets

of the university. I think it is fair to say that the universities should make no profit out of that care. It should come out even. If the patient cannot pay for it, there should be some way in which they can be met at no profit or no loss to the educational budget.

The Dental Approach to the Problem

The schools of dentistry and the dental profession have been doing this very nicely for over 100 years. It is based upon the need of pathology—on the need of diseased and well patients—and on the fact that it is well, economically speaking, that dentists and dental schools have worked together so that a dental school can and will take anybody who wants to go there.

But, whether or not you are accepted for care by the dental school depends upon the need of teaching material of the disease or caries or bridgework or what not that you need. If they have all the gold fillings that they need to train their students adequately, they won't take you. You can go anywhere you want to and any dentist will take good care of you.

It is that sort of program that is being considered by members of medical schools in one form or another. Now, the indirect contributions, of course, are equally important, it seems to us.

Dual Role of Faculty Difficult

I would make the point, however, that it seems to many of us quite useless, from an educational point of view, for a faculty of a school of medicine to be employed in the position of medical care for any given number of people. For example, let's take 100,000 people and show that it is reasonable to assume from past experience that there will be about 40,000 cases of upper respiratory diseases—most of them the sniffles, or minor illnesses, not to be considered as tuberculosis or cancer of the lungs.

It would not be to the best interest of education for a faculty of experts, who are also teachers and investigators, to be required to take care of 40,000 people. They only really need about 600 people with respiratory diseases during the year—if they can select those patients—to do a good job of training undergraduate students. And from experience we might say that out of 100,000 people there will be at least 20,000 cases of gastroneuritis, or perhaps there will be 1,000 cases of malignant diseases.

So it is a selected group of patients that are needed for medical schools, and that cost of taking care of them should be worked out at no profit to the university and no cost to the educational budget.

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Supply of Physicians

Commissioner RUSSEL V. LEE. Dr. Chandler, can we ask you a few questions?

One of the questions that keeps coming up is about this supply of physicians. Are there enough or are there not, and, assuming that there are not enough, is the potential of the medical schools for increasing their numbers exhausted now? I mean, the numbers of student graduates?

Dr. CHANDLER. If I understand your question; no, it is not exhausted. It is, however, unless we can get some more facilities. Our own medical school has a good average example. Our classes are limited to 60 students, not because we enjoy restraint of trade or intend to participate therein, but we do not have 62 laboratory places, we only have 60. What we need is a new building, or a remodeling of the present building, and an addition to it. Then we would be very glad to increase our class to 75—a 25 percent increase. Our committee of the faculty has so recommended.

Now, there is one other form in which this might be met—that is in additional schools. But that is costly and time-consuming, as you know.

I give you the University of Rochester, which was established by a very wealthy man, with endowments and buildings and so forth, and at the end of 25 years—and they did a good job—they have graduated 1,001 doctors in 25 years. You can see that a new medical school is going to cause a great deal of expenditure. It will cost many buildings and much equipment, but the problem will be the staff.

The real problem is the experts, who are also interested in and able to teach and train the next generation. The combination of the two, it seems to me, will meet the problem. How big the problem is, what the number is I wouldn't know. That is debatable, and you have more information than I do.

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Area of Medical School Responsibility

Commissioner DEAN A. CLARK. We are told many times that there is substandard medicine be-

ing practiced in some of the urban communities, in the shade of medical schools, and from your statements you hardly feel that the medical school should be responsible for that type of medicine that is practiced in the city?

Dr. CHANDLER. Well, I don't know what you mean by "substandard medicine." And I don't know who is to decide that there is a standard, but as far as a medical school staff is concerned, I see no place, either in the city or the country, for putting a medical school faculty in private practice of medicine, whether the government pays for it, the individual pays for it, or the union pays for it, or the manufacturers' associations pay for it. What we need is for 60 students in our medical school to have a select pathology from a population of about a million people, in order to get an adequate spread. I believe the University of California is about the same, or a little larger. They are taking 70 or 72 or 73 students now.

As far as having a medical school faculty direct the medical care of a rural population, if that is what you mean, my personal opinion is no. We can do a better job, as has been done in the last 25 years, by training better doctors, having better facilities for them to work with in rural communities; and there are very few areas in California that are more than 2 hours away from a good hospital by automobile travel. That is not true of the Rocky Mountain States and some other places, but I don't think the problem is one that will be solved by the medical school faculties taking charge of medical care in Modesto or Bakersfield, or—I can name some real little ones for you if you know this State.

Commissioner LEE. Is it pretty general that if facilities were increased the output could be increased? Would you say that is a general statement?

Dr. CHANDLER. I think that is a general statement, Dr. Lee, but some of the medical schools are already up to their capacity. You cannot teach obstetrics to 200 medical students on one pregnant bride. You know that. There has to be a little distribution there.

There are a few medical schools that have reached their capacity. Others, I think the majority, could increase their classes and maintain very high standards of education if they had buildings and facilities. There is also some problem

of personnel. We are all robbing each other's chicken roost right now for faculty members.

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Federal Aid to Medical Education

Commissioner ELIZABETH S. MAGEE. I wanted to ask you whether you cared to tell the Commission what your opinion is on the matter of Federal aid to medical education.

Dr. CHANDLER. Well, there are some places aid can be received, and it is pretty broad. I believe, in my own feeling, that there are two places, certainly, that are without much controversy, in which Federal funds, the taxpayers' money, can help medical education. One of them would be facilities. I would a little rather see it at the State level than I would from the Washington level, but I don't care whose money it is so long as it is given to the medical school to use in a given field.

The second one is a problem of student scholarships. Those costs have been mentioned here. I happened to anticipate that question. Our costs at Stanford Medical School for the year just ended, from the educational budget, were \$3,135 for the 9 months, for each 1 of the 240 medical students—\$3,135, and that does not include or account for research budget, and it does not include the teaching hospital and clinic costs, which probably should be included.

Now, this cost is paid for in part by the student—\$787—so that the remainder comes from the university general funds, endowments, gifts and tuition, and we get our share of gifts. Most of them are for specific purposes, I will admit, but that still relieves the university of other costs. Our school received over \$1 million in gifts this year. This is the second time in the last 20 years that we have had over \$1 million to the School of Medicine in gifts, but I don't care if they are for specific purposes. That is fine, as it relieves some other fund.

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Provision of Facilities

Commissioner RUSSEL V. LEE. Dr. Chandler, if the new facilities were provided by State or Federal Governments, do you think the private medical schools could stagger along and survive?

Dr. CHANDLER. No, they wouldn't stagger at all. Commissioner LEE. They would be all right?

Dr. CHANDLER. They would be all right. I am sick and tired of hearing people say how the University is broke because their medical schools have a deficit. You don't talk about a deficit to the library or the chapel, you decide whether you want a chapel or a library or a school of medicine, and then you go ahead and pay those educational costs. It is these other costs that are really hurting, and I see a perfectly clear way to do it. Our California State Society has a special committee to explore the use of such patients as are needed in limited numbers for training purposes by five medical schools in California.

Commissioner DEAN A. CLARK. Do you think that the research should be financed by the medical school in general?

Dr. CHANDLER. If I could have it that way, I would like it very much. I think it should be financed, in part at least, by medical schools. I don't think a medical school would be complete without some moneys of its own, either by a gift or endowment or current gift. That is, its own money to use in research by its faculty, and a school that is worth its salt in name has members of its faculty who know what makes the wheels go around, whether it is clinical research or fundamental laboratory science. I think part of that should be financed out of money controlled by the school. Most of us are sick and tired of projects financed by year-to-year funds. It is not good fundamentally. That is not a very good answer to your question, but I covered it, I think.

Statement¹ of

DR. W. P. RICHARDSON

Associate Dean

School of Medicine

University of North Carolina

The problem of medical personnel in rural areas . . . is not something for which there is any single or any simple solution, and many of the factors are related to the responsibilities of the community.

As Dr. J. Street Brewer (President, Medical Society of North Carolina) so ably pointed out, there are other factors which are related to it outside of the community and which give an opportunity for medical schools, for example, to make

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

a contribution in this area. Dr. Davison pointed out the problem of recouplement of medical students from rural areas, and this is, of course, one of the very serious problems.

At the university, our experience has not been quite so disturbing as Dr. Davison's. Over the past 5 years, we have admitted a total of 285 students of whom 179, or 63 percent, came from urban areas, that is, communities over 2,500; 74, or 26 percent, from towns under 2,500; and 11 percent, or 32, from R. F. D. addresses.

Physicians for Rural Areas

Of course, there is no assurance in getting students from rural areas that they are going back to rural areas to practice, although the experience of other States has been encouraging and has, I think, indicated that the vast majority of physicians who are going into rural areas are people who have originally come from rural areas.

One of the very serious problems in physicians going into rural areas, I think, is the matter of professional isolation. A doctor who has come through 4 years of medical school and several years of internship and residency, in the pattern of modern medical education, feels very loath to go out into a community where he is not going to have the opportunity of daily contact and interchange with his professional fellows and where his opportunities for professional growth and development are going to be limited.

Continuation of Education

There is one contribution to this problem which medical schools can make, which we are making to some extent, and which we need to develop far more fully, and that is a broad and extensive program of continuation of education.

The program of continuation of education of the University Medical School was initiated in 1910 as a result of requests by the medical profession of the State, and it is on the request and demand of the physicians in various areas of the State that this program has been continued to the present time. It is a very limited program, and we have hope and ambition as a part of the expansion of the Medical School and the program to be able to broaden and extend it in a very large measure.

Preceptorial Program

Another contribution, of course, which medical schools can make toward securing physicians for rural areas is illustrated by the preceptorial pro-

gram of rural physicians which Duke University has. Another approach to this problem has been carried out by a great many medical schools, which is the provision of a period of internship or residency in rural hospitals and rural communities as a part of the internship and residency program.

This is rather difficult under present conditions because the military situation is such that interns are called into service as a rule after 12 months of internship, but in the future, when we have the opportunity to keep them a little longer, it is the intention of the University Hospital to try to work out, insofar as feasible, a plan for interns and residents to rotate through smaller rural hospitals, and thus become familiar with the conditions of practice and the opportunities which such communities provide and with the pleasures and satisfactions of living in smaller communities.

Finally, I should like to say that I am sure that I represent the attitude of the University Administration and the Medical School when I tell you that we recognize that this is one of the foremost problems for which the State provided the expansion of the University Medical School and Medical Center, and we pledge our best efforts and our fullest cooperation in helping to meet these problems by every means at our command.

Statement ¹ of

DR. C. C. CARPENTER

Dean

The Bowman Gray School of Medicine Winston-Salem, N. C.

I would like to comment particularly on the distribution of physicians.

I was interested in the statement made by Dr. Brewer (president, Medical Society of North Carolina), in which he said that part of the responsibility must remain with the local community. That is, physicians happen to be normal human beings who feel a great responsibility for the welfare and education of their wife and family. So they go to the community where they have good churches, good schools, and good communities in which to live.

Now, we do not have any difficulty in our school in locating our graduates in such communities. I suppose that the largest number or, I know, by far that the greatest number of our graduates

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

up to now, have gone into general practice, and a majority have gone into rural communities.

I would like to comment also on the matter of the number of students entering medical schools, that is, the general qualifications of the applicants. It is true, as Dean Davison said, that medical schools of the United States last year admitted 7,000 out of 22,000 applicants. But that is a very misleading statement on the face of it, because I doubt very seriously whether more than 10 to 15 percent of those declined were qualified to study medicine.

I would also surmise that perhaps less than 5 percent of the qualified applicants to the three medical schools of North Carolina who were from North Carolina have been declined. I can think of no case where we have declined a qualified student who applied to our school for admission from North Carolina.

So we are taking care of those who are qualified, and we need better education. We are getting the doctors out into the communities, and I think the rural communities are going to have better medical care and better distributed medical care just as fast as the communities improve.

Statement¹ of

CHARLES E. SMITH, M. D.

**Dean of the School of Public Health
University of California
Berkeley 4, Calif.**

It is a privilege to be invited to appear before this Commission. May I say that my remarks are an expression of personal views and in no way present an opinion of the University of California or the California State Board of Public Health.

The health problems of which I should like to speak are two, which interrelate. One is the recruitment of public health personnel, especially physicians. The second is the financing of education for the health sciences.

Recruitment in Public Health

With respect to recruitment in public health, Dr. William P. Shepard's analysis of "Manpower Shortages in Official Health Agencies" in the August 1952 *Public Health Reports* reveals that 10 percent of all budgeted positions of State and local health departments, including 20 percent of

those for physicians, are unfilled. The unfavorable status of salaries in health departments is the principal reason for this serious problem. An example may be noted in the very department where we are meeting today. Is it any wonder that even our able Director of Public Health of the city and county of San Francisco cannot recruit a physician trained in public health for the position of chief of his Division of Venereal Disease when the salary is only \$650 a month?

This manpower shortage is worsening. Recruitment of physicians for public health lags farther and farther.

The proposed national legislation for Local Health Services is endorsed by all public health groups. Its passage is a basically important health need of our Nation. However, it will increase even more the competition for our inadequate number of trained workers.

Alleviation can come only if the salary levels of the already functioning health departments and those to be established can be set at a level enabling them to compete with private employment or practice. Moreover, the demands for competent, trained American public health workers to develop programs abroad grow increasingly insistent. This further accentuates our critical manpower shortages. The first step in meeting them is the provision of adequate salary levels.

Provision of Financial Support

A second vital area of health need is the provision of financial support to the institutions training health workers, and as a corollary, conducting research in the health sciences. We need only allude to the high cost of training each physician, dentist, and public health worker. Such training is very expensive, requiring close personal contact with teachers and a resultant high ratio of teachers to students.

Moreover, medical schools have developed a pattern of providing medical services to most communities in order to have clinical teaching material. Thus the universities with medical schools not only provide large faculties but also subsidize the medical care of their communities. Moreover, the invaluable expansion of research support has created a further drain on the universities.

Research Needs

Research must accompany teaching if the latter is to be dynamic and effective. However, the

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

necessary physical plant and overlooked factors of overhead may make research grants a liability and accentuate the mounting financial crises of our universities. A symptom is the staffing of academic teams. For instance, grim as recruitment is in health departments, most schools of public health cannot even compete in salary opportunities with health departments.

There are possibilities for the alleviation of some of these problems. For schools of medicine and dentistry, one of the first steps should be assumption by the communities of the full cost of providing the medical and dental services to part-pay and no-fee patients, hospitalized and outpatient. The pattern of the Langley Porter Clinic of this State is an example, merging medical service and teaching on an equitable basis. Moreover, private patients, including insured groups, might be used for teaching. This is already done in residency programs and in a few universities.

There are psychological barriers. The relationships with colleagues not on the faculties of the schools seem as delicate and difficult as those with patients. However, opportunities must be provided for clinical teaching without requiring the universities to continue to finance the medical care programs of the community.

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Alternatives to Governmental Aid

We should continue to seek alternatives to governmental aid to universities teaching the health sciences. When Government funds are used, rules must be established to insure an accounting to the taxpayer through his legislators. Unless care is exercised, such control could interfere with academic freedom. Moreover, the mounting tax burden is only too familiar to all of us.

By means of regional compacts, States are attempting to resolve some of these problems without Federal aid. These efforts, like those of support from alumni, industry, or the general public, are most desirable. However, time is running out. Universities must not be forced to choose between jettisoning their schools of health sciences or imperiling their solvency.

The amounts necessary for such supplementation as would be required to prevent bankruptcy are very small. The primary concern must be a method which would guarantee academic freedom, especially freedom from political interference.

Fortunately, patterns have developed in recent years which are applicable.

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Specialized Scientists Pass on Research Applications

A second example in safeguarding individual responsibility is even more directly applicable. At the end of World War II the Public Health Service was required to assume responsibility for the contracts let by the National Research Council as part of our war effort. As a modest step in the vitally necessary development of medical and health research, this Federal aid was continued and extended.

The National Advisory Health Council was made responsible for passing on the applications. However, the National Advisory Health Council, even though then composed entirely of national professional health leaders, found the task of evaluation too highly specialized for it to handle fairly.

Accordingly, under the Division of Research Grants and Fellowships of the National Institutes of Health, groups of specialized scientists were appointed from universities and research institutions of various parts of the country to appropriate study sections. Three times each year the study sections met, decided merits of applications and sent their recommendations to the National Advisory Health Council, which practically always followed the recommendations.

With the establishment of National Institutes and their accompanying National Advisory Councils, the research program was extended and the National Advisory Councils included nonprofessional representatives as well.

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Merit Is Sole Consideration

Having served on a study section and on a National Advisory Council, I can attest that a member never feels any evidence of pressure or direction. The sole consideration is the merit of the application. A similar pattern of Federal aid seems possible for schools of medicine, nursing, public health, dentistry, or other health sciences. If policies would be set by the educators who alone know their problems, these professional schools could continue to develop in a spirit of freedom and initiative.

In summary, the problem of recruitment of public health personnel is a critical one. Ten percent of budgeted positions and 20 percent of physicians' positions are unfilled in health departments. Personnel needs are increasing, but recruitment will lag until salary levels in health departments can compete with private employment or practice.

Critical Problem of Financing

A second critical problem is the financial support of institutions training workers in the health fields. Opportunities for clinical teaching must be afforded our universities without continuing the requirement that they finance medical care programs of their communities. However, the high ratio of teachers to students as well as the hidden costs of the necessarily active research programs make the schools for the health sciences exceedingly expensive for our universities.

If other methods for resolving this problem do not develop very soon, Federal aid to these programs must be provided. Developed in the pattern of our own State's Public Health Assistance Act, the Hospital Construction Act, or even more comparably, the Research Grants Division of the National Institutes of Health, policies could be set by the educators who alone know their problems and could continue to develop those professional schools in a spirit of freedom and initiative.

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Dr. SHEPARD. Dr. Lee would like to ask you a question.

Question of Shortage

Commissioner RUSSEL V. LEE. Dr. Smith, is there a real shortage of trained personnel in the public health field now?

Dr. SMITH. As Dr. Shepard has indicated in his own studies here, throughout the country 20 percent of the budgeted positions for physicians are unfilled.

Commissioner LEE. Would you favor subsidizing medical men to study public health—to give students who are interested in public health a subsidy while they are taking training, as a method of providing more personnel?

Dr. SMITH. I think the principal problem is with the ultimate ceilings that they have and the financial remuneration that they can have in their profession subsequently. As far as the actual training program is concerned, for the person who

is to be a specialist in public health and qualified for the American Boards of Preventive Medicine and Public Health, opportunities for training and support while they are undergoing training compare quite favorably with those, in fact somewhat better, than those for training in other specialties.

The crux of the matter comes from the ultimate position to which they can aspire. And I think that right here in our own San Francisco Health Department we have an example which could be cited. Despite the fact that Dr. Sox, our executive director, is exceedingly able, it is not possible for him to recruit a physician trained in public health for the position of chief of his Division of Venereal Diseases when the salary is \$650 a month. I mean, that is a specific example of the problem that we meet as a major part of our serious problem in recruitment.

Aid to Public Health Schools

Commissioner LEE. You mentioned aid to public health schools. Would you separate that from general aid to medical education? Is it a special or more acute problem than that of general medical education?

Dr. SMITH. Speaking now entirely for myself, and not representing the University of California, or the State Health Department—speaking for one C. E. Smith—optimally I should say that they should all be brought in together.

However, if for purposes of facility in developing these programs it is more expedient to separate them, then I think that would be quite in order. However, as I have indicated, all of the health specialties are professional schools which are exceedingly expensive; and while—as I have indicated in my full statement—it is of great importance to carry on the attempts from alumni, from industry, from private philanthropy, from all sources to meet the need, nevertheless there still remains such a drain on the universities that have these professional schools that some answer is going to have to be arrived at—and arrived at soon—if we are going to preserve the universities from either going into bankruptcy or jettisoning some of their very expensive professional schools for health.

Neither alternative is desirable, and the important point is to try to make this sort of plan work without jeopardizing the academic freedom and integrity of the institutions.

English vs. American Public Health Training

Commissioner DEAN A. CLARK. May I ask a question, Dr. Smith? Would you be willing to compare the English training for public health work with the American training? There is quite a discrepancy, is there not, between the length of training period in the two countries?

Dr. SMITH. The English have for scores of years the tradition of going into public health and getting the diploma in public health, the DPH, without any subsidy from without. It has been acquired and has been sought after by the person who wants to become an MOH, a Medical Officer of Health, and he has paid his own way and gone right ahead.

Through the years, until there were certain unfortunate repercussions of the change in their national legislation, the opportunities in the public health field for an MOH were quite attractive compared to what he would have in private practice, so that there were plenty of British physicians who sought to go and take their training in their individual schools and universities.

It was not established on as broad a scale in their education as we have had here. Indeed, many of the British medical faculties also taught one or two DPH students. When the National Health Act went through in Britain the full-time MOH had a much less advantageous responsibility and opportunity, both from interest and finances, than was previously the case, with the result that there has been a great deterioration in the number of students that have been going on and taking their DPH's.

From the point of view of training we have operated on a somewhat different basis in this country, in that our policy has been to attempt to have a smaller number of schools, most of which would attempt to train a panorama of people who were in the health agencies, rather than just one or two, principally MOH's, for administration.

We have attempted in our schools to teach not only the physician for the administrative operation, but also public health, nursing, maternal and child health work, health educators, laboratory specialists, sanitary engineers, biostatisticians, who, by virtue of the fact that they would be together in one school would be able to have the opportunity of working with the other members on the health team. That is a much more expensive type of operation and has ballooned costs, because we feel that just training a small com-

ponent of the team is inferior to training the entire group.

Commissioner CLARK. The training period in England is about 2 years, is that correct?

Dr. SMITH. The training period in the United States for the academic training is only 1 year, but if one is to go on further there is an additional period. For instance, our specialty boards in preventative medicine and public health require an additional 5 years, with 2 years of actually supervised experience.

Statement¹ of

DR. CHAUNCEY D. LEAKE

**Vice President and Dean of the Medical Branch
of the University of Texas
Galveston, Tex.**

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For the successful promotion of the best health possible for our people, extraordinary efforts will be necessary in the development of team work among experts in many diverse fields. Health includes not only good physical health and good mental outlook, but also economic stability and security, as well as clean, comfortable, and convenient physical surroundings. The challenge to the best possible health for our people is therefore a call to the abundant good life.

From the practical standpoint of the health services, however, the matter can be narrowed to the proposition of promoting the best possible physical and mental health. An imposing program is already under way in the field of mental health. The techniques here developed might be fruitfully applied in other aspects of the health program. The example given by the Armed Forces Health Service might also be followed to advantage.

Half Century of Effective Teamwork

For half a century now we have witnessed the extraordinary success of effective teamwork among the health services in the field of child health and welfare. The pediatric program has won a warm response from people everywhere, and our people are immeasurably the better for it. It has established the firm foundation for continuance into adult life, and, indeed, in preparation for old age. The program has involved

¹ Delivered at the Regional Hearing in Dallas, Tex., August 18, 1952.

research, organization, teaching, and then practical application along pragmatic lines toward the goal desired.

Health centers might well take this example seriously. Doctors were learning to work more effectively all the time with dentists, pharmacists, nurses, clinical laboratory technologists, radiology technologists, physical and occupational therapists, veterinarians, medical case workers, sociologists, clinical psychologists, public health officials and workers, hospital administrators, and even medical artists and librarians. Here is a remarkable list of health auxiliaries. These constitute the elements of the team involved in the program for the best possible health for our people. Naturally the doctors should be the leaders.

It is incumbent upon the members of the medical profession to do everything possible to encourage the best sort of understanding among all members of the health field that they are working together toward common ends, and working together as a team. It might be appropriate to suggest that members of the medical profession will have to learn individually to give increasing respect and attention to all other members of the health team, in order to promote good teamwork, cheerful morale and effective results.

Conferences on Health Teamwork

Medical organizations at the local, State, and national levels, might be wise to invite representatives of organizations comprised of other members of the health team to meet with them at regular sessions for the discussion of health teamwork. It might be appropriate to suggest the development of over-all conferences at local, State, and national levels, with representation from all of the organizations involved in the health team, for the purpose of developing good team play, and a practical program. Certainly John Q. Public and his wife would be interested.

Here would be afforded an extraordinary opportunity for the development of the democratic principle in relation to our most important asset, which is our individual and collective health. Such a proposition might be worth the careful consideration of some of the great new foundations which are being established for the promotion of our welfare.

Health teamwork on a broad scale could well become the major objectives of State university health centers. Here could be brought together

research workers, teachers, and expert service personnel to represent all parts of the health team. Working in common with close association with each other, so that recognition could come of the importance of all in the team, would engender mutual stimulus, inspiration, adaptation, and understanding. Perhaps under these circumstances the artificial, social, economic, and prestige barriers that now exist between the various health workers, could be eliminated.

The Compulsion To Justify a Trust

Why should we not dream of Utopia? It is only by giving ourselves noble and exalting visions of what might be, that we are able to make even faltering steps toward them. The obligation is particularly heavy on members of the medical profession to show that generous understanding of the situation which would encourage the confidence of all other members of the health team. There would then come the necessity of justifying the confidence. There is no greater morale force than the compulsion to justify a trust. Perhaps we can learn to take a few steps toward a health Utopia.

In considering the expanding tradition of health service, one can trace four phases involving (1) primitive methods of medical care by relatives, friends, and priests, (2) organized and systematic care of the sick by professionally trained personnel; (3) efforts toward the prevention of disease by public health service and by individual immunization; and finally (4) emerging programs for the development of the best possible physical and mental health of people.

Value of Teamwork

Many aspects of the old traditional approaches survived and will continue to remain as new logical expansions occur. Increasingly apparent is the general awareness of the value of teamwork in regard to the health services. Many specially trained persons are currently comprising the health team, and others may be profitably incorporated. As now constituted the health team includes doctors, nurses, dentists, public health workers, pharmacists, veterinarians, clinical laboratory technicians, radiology technicians, physical and occupational therapists, sociologists, and case workers, clinical psychologists, hospital administrators, librarians, and medical biological research workers.

In each of these categories there is ample opportunity for a rich professional career. University health centers for research, training, and service in these fields have an inspiring opportunity for still further expanding the rich tradition of the health services. If the proposal seems over optimistic, too visionary, or excessively idealistic, make the most of it anyway.

I do believe that we do not use sufficiently the resources available in our universities, and you would be surprised how much mud is on the shoes of the ordinary university medical professor. He is not in an ivory tower. He is not going to come to you and try to tell you what to do; he isn't that kind of man. But if you will come to him and ask him, he will be glad to help, and I think in this part of the country, you have got as fine a group of universities available for all phases of teaching and research in the health fields as you can want to get.

Finally, let me say I believe our most important need for us here—or for any other part of the country—is for all of us who are interested in health affairs to get together more often in sessions like this.

Statement¹ Submitted by

DR. STEPHEN A. SHEPPARD

President-elect

Cleveland Academy of Osteopathic Medicine and Surgery

Fairview Park, Ohio

Critical Shortage of Trained Physicians

The Cleveland Academy of Osteopathic Medicine and Surgery respectfully submits for the consideration of the Commission the fact that underlying all these major problems and objectives outlined above is the critical and continuing shortage of adequately and completely trained physicians.

This is true in spite of all the help and encouragement given by the government in recent years to medical schools in an attempt to make possible an ever-increasing number of well-trained physicians.

This shortage, however, when viewed objectively is seen to be more aparent than real. There are thought to be approximately 120,000 allopathic (MD) and 12,000 osteopathic (DO) physicians

and surgeons presently engaged in active practice in the United States.

Unequal Opportunity for Practice

If we may accept these figures as reasonably accurate we must then assume that about 10 percent of the health problems of the Nation could be cared for by osteopathic physicians and surgeons.

These men and women graduates of osteopathic schools of medicine and surgery are ready and willing to assume their proportionate responsibility for the problems confronting this Commission, but they are being prevented from doing so at this time.

Today most states license graduates of osteopathic medical schools to practice in a manner identical to that by which graduates of allopathic schools are licensed.

The scope, quality, and duration of training of all these physicians is for all practical purposes identical. The osteopathic schools have assimilated and now teach complete courses in basic sciences, medicine, surgery, obstetrics, pharmacology, and the specialties, in proportion to these subjects, as taught in allopathic schools.

The allopathic schools have also added to their curricula and are giving increasing study to problems of body mechanics, manipulation, and the inherent resistance of the human organism to disease. This has been the situation for at least a period of 10 years.

Maintenance of Identity

The major differences of opinion between these two great schools of medicine are, therefore, actually a thing of the past. Yet the training and ability of the minority group is not being used to the full extent that it might be as a result of the fact that each school wishes to retain its identity and maintain control over its colleges and their graduates. This is understandable, and in some situations may be recognized as a distinct benefit to the health of the Nation.

There is no logical reason, however, to explain the fact that physicians and surgeons who are licensed by the various States as unlimited practitioners are prevented from serving as commissioned officers in the Armed Forces of the United States.

Discrimination in Insurance Programs

There is a similar difficulty encountered in rationalizing the need for preventing such physi-

¹ Submitted at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

cians and surgeons to take an active part in certain insurance programs written for the benefit of the people. It is extremely hard to reconcile the fact that these physicians and surgeons are licensed by the various States, but may not fully employ the health facilities of the States, despite the fact that these facilities have been provided and are maintained for the public benefit by the public through the use of tax money and funds raised by general subscription.

This means that 10 percent of the physicians and surgeons of the United States of America may not use the existing facilities already provided by the Federal, State, and local governments to help in the solution of the tremendous problem confronting this Commission today.

Problem of Health Care Basically Manpower

It is generally conceded by those who have studied the situation, and is certainly, therefore, most apparent to the members of this Commission that the problem is basically one of manpower.

The construction of additional hospital beds, the increase in the number of public health units, the stepped-up tempo of medical research, the needs of the chronically ill and aged, and adequate health services to all income groups are and must be secondary to the problem of providing adequately trained people to do the job.

The President's list of problems is therefore topped by the one of maintaining an adequate supply of well-trained physicians.

A pool of 12,000 physicians and surgeons is ready to be utilized immediately with another 2,000 in training. How can this Commission most effectively employ the services of that group in achieving a solution to the problems presented?

The Cleveland Academy of Osteopathic Medicine and Surgery also submits the following suggestion for the consideration of the Commission and all others interested in helping to solve the health problems of this Nation.

National Council on Medical Education

If the Commission considered it wise to do so, it might suggest the establishment of a National Council on Medical Education, the members of which could be made up of representatives of both major schools of medicine. In addition, the Council could consist of representatives from management, labor, farming, allied professions, and other groups vitally concerned with the problem.

This National Council of Medical Education could then inspect all medical schools whose graduates are eligible to practice general medicine and surgery in the various States. The Council could approve, on a yearly basis, each of these medical schools, and if one or another fell below the minimum requirements for approval, the school could be given a grace period of 12 months to right the situation.

If adequate progress had not been made in that period of time, State or Federal aid might be prescribed by the Council for the benefit of the school in question.

Facilities Available to Graduates

Graduates of all schools approved by the National Council on Medical Education could then be eligible for military medical service.

They could employ the facilities of the people to care for the people. Federal, State, and local hospitals and other health facilities would be available without question to the graduates of these approved schools, regardless of the degree they employed to designate themselves as physicians.

Graduates of any of these approved schools could be eligible for internship or residency training programs in any hospital approved for training purposes by either the allopathic or osteopathic groups. Physicians graduating from any of the approved schools could anticipate equal opportunity to serve in any branch of government medicine. They could be eligible to teach in any of the approved medical schools without risking the onus of unethical practice or the criticism of their colleagues. Graduates of all approved colleges could consult with one another and enjoy a free exchange of ideas, the lack of which has stifled medical progress and real cooperation between the professions for generations.

Such a program would in no way interfere with the normal or usual activities of either the American Medical Association or the American Osteopathic Association. Each would continue to maintain its journals, conventions, specialty colleges, certification boards, and so forth; but instead of pulling in opposite directions they could effectively work together for the benefit of the American public during and after this emergency period. This program could allow each association to join with the other for the welfare of the people without loss of face, reputation, or stature

on either side. It is safe to predict that if this Commission allows these medical groups to work out their differences without the establishment of such a national council on medical education, it will be generations before the full effective force of all adequately trained physicians and surgeons will be available to solve the health problems which confront us today.

Statement¹ of

REV. E. T. FOOTS, S. J.

Regent

St. Louis University Schools of Medicine

St. Louis, Mo.

I wish to enter a few remarks about the effects of actions taken to meet military, civil defense, veterans, and other health needs upon civilian health care.

There are obvious effects: The recruitment of medical personnel by various governmental agencies has forced private institutions and agencies toward higher and higher salary expenditures and has depleted the available supply of such personnel. There is the so-called "doctor-draft" which up to the present time has had serious direct effects upon residency and indirectly upon internship programs, and consequently upon the excellence of medical care in hospitals and upon educational and research activities.

Effects upon intern-level medical education include these: That disruption or hampering of residency programs interferes with interns' supervision and instruction, as well as the maintainance of the best organization of service units in some hospitals.

Effect of Military Internships

Furthermore, recruitment of medical graduates for military internships surely aggravates an already existing problem arising because the intern demand of hospitals is far greater than the number of available graduates. We must hasten to add, however, that the policy thus far followed by drafting authorities is to be praised because the graduate is allowed, if he so desires, to complete the year of internship before his deferment will be discontinued.

It is sound thinking which recognizes the importance of regarding the internship as the

necessary continuation of the physician's graduate education. Public Law 779 and pressure and/or enticement procedures toward the recruitment of physicians seem to be having one effect which is diametrically opposed to a solution to the so-called doctor-shortage problem. At the bottom, one of the most significant factors limiting the education of more physicians is faculty shortage.

For the development of faculty personnel, particularly of physicians interested in and competently trained in the basic medical sciences, but also of those who would enter academic medicine, it is important that during the 3 to 5 years following graduation from medical school the future teachers be able to proceed with their own further studies and then with the beginning of their teaching and research activities. Therefore, it is probably rather short-sighted indiscriminately to deflect every young doctor from this continuation by requiring his military service shortly after internship or its equivalent. . . .

* * * * *

Draft and Deferment Policies

Related to continued maintenance of a desirable standard of civilian health care is the education of students for medicine. Drafting and deferment procedures have in the main been so planned and administered with regard to students entering medicine that there seem to be no untoward effects. Selective Service is to be complimented in this regard. Apt and worthy candidates for medical school have been able to progress through the requisite preparatory collegiate studies and enter medical school without interruption.

Another policy which is correct and should surely be continued is that of leaving the summer vacation periods at the disposal of the medical student, not only because in certain of the schools instruction continues through the summer preceding the senior year, but also for the psychological and physical health of the student and for his financial position. Many students depend upon summer earnings to finance their medical education.

Acceleration of Medical Education Detrimental

It is reassuring that acceleration of medical studies is not being urged. It seems not only shortsighted but unrealistic to entertain the notion that medical education can without detriment be

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

accelerated. Faculty shortage is one of the reasons; the essential nature of medicine is another.

In medicine, the student and teacher alike must preserve and nurture a certain inquiring attitude of mind, a certain thoroughness, a certain interest in advancing medical science itself; a series of crowded semesters or trimesters without interstices may be satisfactory for emergency indoctrination in engineering or tactics or languages, but it hampers formation of the student of medicine into a true physician. The medicine to be learned is more than a body of organized knowledge, and even if faculty and student were tireless, accelerated medical education would be of lower quality.

* * * * *

Medicine More Than Science and Skills

. . . Medicine is more than science and skills. It has its reality . . . in physician and patient; it is not just a number of tests and diagnostic judgments; it is not merely the patient's receiving certain therapies . . . it includes certain attitudes . . . purposes, motivations of both patient and physician. There are quotients of interest and desire for well-being, of confidence and trust and gratitude, elements not unlike friendship

Now, since these rather awkward-to-describe features are concrete in the persons concerned, rather than merely in an objective body of knowledges and skills, changes in persons and in their attitudes mean changes in something essential to medicine in action.

If then, we note the growth by millions of the total of all the government employees, all service personnel, all veterans, all dependents, and all the others receiving government purveyed medical care, we immediately appreciate that if in this medical practice there is deterioration of attitudes and approaches on the part of patients, you have a tremendous sector of our Nation's medicine affected. Add to this the fact that universal military training will place each young man in contact with such medicine for an important period of his life

If medicine comes to be—and as far as they are concerned—a kind of commodity, a service given to them or issued to them as are their uniforms or their food rations, they will soon forget what the traditional private practice of medicine means.

* * * * *

Medical Devotedness Cannot Be Evaluated in Dollars

Whatever the mechanics by which it is accomplished, if the great majority of graduating doctors is required to spend all or a part of the years immediately following medical school or internships in an atmosphere where traditional privately practiced medicine is impossible, it is evident that the next generation of physicians will be in danger of regarding themselves as dispensers of a commodity, as persons who unthinkingly let medical devotion be evaluated in dollars, who limit their medical responsibilities to a 40-hour week.

We must insist upon, encourage, and support the most intensive and extensive medical research—so that less and less diseased conditions will have to be classified as beyond helping, so that there may be ever improving preventive medicine. It is not reasonable to deny that there is need for better distribution of medical personnel.

I am, however, posing the sober question whether we should glibly seize upon catch phrases concerning “more doctors,” “more and better health facilities;” whether we should somewhat blindly jump to the possibly gratuitous conclusion that government, and Federal government in particular, must produce more physicians, must attempt a “sickness tax” monstrous enterprise—when we are failing to take the obvious steps to improve health and extend life which are within our grasp regarding housing, nutrition, instruction, safety. For some of these measures, public health activities and responsibilities are necessary, and these are very often adequate at local community levels.

Statement¹ of

WILLIAM J. McGLOTHLIN

**Consultant for Professional Programs
Southern Regional Education Board**

I would like to talk with you about the program which the Southern Regional Education Board, of which the State of North Carolina is a member, has been conducting in the Southern States. The Board was established under the Regional Education Compact, approved by the legislatures of 14 Southern States, from Maryland through Texas, and Kentucky through Florida. Governors of these 14 States, plus the Governor

¹Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

of West Virginia—which has not approved the compact—make up the Southern Governors' Conference.

That Conference conceived the idea of regional—that is, interstate—cooperation in graduate and professional education after a long series of annual discussions. In 1948, the Governors drew up and signed a compact which would become operative only when the legislatures of six States approved. By 1949 more than enough had approved, and the Board was formally established in June of that year to carry out the purposes of the compact.

Graduate and Professional Education

Briefly put, the compact proposes that the the Southern States obligate themselves to cooperate in providing graduate and professional education, either by joint ownership and operation of regional schools, or by joining present institutions into relationships through which they can better serve the needs of the region. It established the Board as an agent of the States in furthering these purposes. The Governor of each State is a member of the Board, *ex officio*. He appoints three persons from his State to serve with him, one of whom must be an educator. In actual practice almost all the appointments have been of educators

In the name of the Board, the staff serves as a central planning agency and clearing house to stimulate and guide cooperative activities among States and colleges and universities in graduate and professional education. It has executed contracts with States to provide them with needed educational services, and it has contracted on the other side with colleges and universities to obtain those services for the States. Contracts have been executed with 19 colleges and universities in medicine, dentistry, veterinary medicine, and social work.

In 1951–52, under these contracts 836 students attended schools supplying these regional services. Twelve States entered contracts for medical places, 11 for dental places, 10 for veterinary medical places, and 3 for social work places. They paid a total of \$1,118,625 to the Board for transfer to the schools. This is not scholarship money, but funds to help support the schools themselves.

For 1952–53, the number of students will rise to something over 1,000 and the amount of money to be transferred to nearly \$1,400,000. And, I

might add, that this is new money that was not available to education in the region prior to this program.

Dovetailing Regional School Curricula

In addition to executing and administering the contracts, the staff is developing a long series of "memoranda of agreement," under each of which the schools and the Board agree to plan together periodically in a particular field so that the offerings at each school can be dovetailed with those at the others, and the region served adequately thereby.

Under these agreements, there will be no transfer of funds and no quotas of students. Instead there will be joint planning and joint execution of graduate and professional programs of education. The staff aids through bringing the schools together, providing them with facts on needs and opportunities, and helping to carry out agreements once they have been executed by finding new sources of support.

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Distribution of Those Selected

Each of the fields in which contracts have been executed—medicine, dentistry, veterinary medicine, and social work—has relationships with health. Details on the amounts of money and numbers of students, and where each comes from and goes to, have been placed in the record and need not be repeated here.

Of the 836 students attending schools under regional contracts, 335 were in medicine, 240 in dentistry, 235 in veterinary medicine, and 26 in social work. 243 of the 836 students were Negro students, and 593 of the 836 were white students. For all, the procedure was the same.

A State which wishes to obtain places for its students enters a contract with the Board. The Board in turn contracts with accredited schools for specified quotas of places. The State then certifies students as to their legal residence.

From these certified lists, the schools pick the qualified students for admission up to the quota. For each student admitted each year under the quota, the State pays to the Board \$1,500 in medicine or dentistry, \$1,000 in veterinary medicine, and \$750 in social work. These amounts are intended to reflect the costs of instruction less tuition. The student is located. He does not pay

out-of-State fees, but he does pay the regular tuition. Payments by the Board are made direct to the institution.

Substantial Benefits

The benefits of this part of the program—that is, the contracts—have been substantial. It has saved States contracting for services millions of dollars that otherwise might have been required to build similar schools. It saved one institution

from closing, and has prevented a 35 percent reduction of students at another. It has spread the base of support and thereby released funds for needed ends. It has enabled a number of students who otherwise might have been prevented from entering on chosen studies to follow their inclinations and abilities. By broadening the area from which students are drawn, it has increased the quality of students, and thereby will increase the quality of health services which they later provide.

Part V

HEALTH PROBLEMS VOICED

HEART DISEASE

Statement¹ of

MRS. MARGUERITE L. INGRAM

Executive Director

**The Illinois Heart Association, Inc.
Springfield, Ill.**

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With regard to rheumatic fever and congenital heart disease, we have found that there is approximately 1 child to every 100 school children who is afflicted. It is estimated that 20 percent of our population in the area falls within the group of school children who are in kindergarten to high schools.

Therefore, as we have about 4,000,000 in our area, 800,000 who are of school age, this means that we have 8,000 children with possible rheumatic fever or congenital heart disease.

Rheumatic Fever Problems

We have found that it is difficult to diagnose rheumatic fever, that many of the symptoms found in rheumatic fever are common to other childhood diseases.

There is the problem also of the need of observing these children over a long period of time in order that a definite diagnosis can be made.

With the incidence of rheumatic fever coming within the age group of five to high school age, it would seem that the interest of the school system in carrying on this program is of major importance. The cooperation of many agencies in carrying on the rheumatic fever program is needed.

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Participation Community-wide

It is obvious that many groups, skills, professions and agencies can and should participate in a program for rheumatic fever.

Where we have a Visiting Nurses Association, we have the facilities through which follow-ups on these matters can be made. It is true, however, that in our area there are very few cities that have that type of service. In establishing county health units, which are so necessary therefore in the follow-up and care for rheumatic fever patients, we have found that several difficulties are encountered:

We have physicians interested in the heart program who are working very hard to establish rheumatic fever programs in their local communities. They realize, however, that in order to provide a sound program, a county health unit is a real necessity. Those physicians, therefore, are leaving those communities and are trying to get a health unit. They find sometimes that they do not always have the wholehearted support of all the members of the medical profession.

These leaders who are endeavoring to set up a county health unit, and a rheumatic fever program, say that they are discouraged because they realize that, if they are successful in obtaining approval for the establishment of a county health unit, they still have to face the problem of finding a staff for the unit. They know that some of the counties in the State have obtained approval, and some of them still do not have medical directors and adequate nursing personnel for the health unit.

Convalescence

We have a problem of convalescence in regard to rheumatic fever patients. We have no special convalescent hospital facilities in our area. There

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

are several in Chicago but that, of course, is in the far northern part of the State, and this means that much of the State of Illinois is unable to take advantage of those convalescent facilities for rheumatic fever patients.

Most of our care, therefore, for rheumatic fever patients is carried on in the home. Public health nurses are, therefore, needed not only to serve in providing the necessary nursing care, but, in addition, to serve as a coordinating agency between the school, the home, and the many other agencies that are necessary to help the rheumatic fever child in some capacity.

Five percent of our people in the area, so far as any program for heart follow-up is concerned, do not have facilities for this follow-up.

Diagnostic Consultation Service

Our executive committee recently approved a program for setting up diagnostic consultation services on rheumatic fever and congenital heart disease for rural areas. The State has a division of service for crippled children, supported by State and Federal funds, but only one diagnostic clinic for rheumatic fever has been established for the children in the downstate area.

However, some cases of rheumatic fever are examined in the general children's clinics which are held periodically in two places in the State.

This division also receives some appropriations which can be used for aiding in the care of the children who are helped by surgery.

This service is not reaching all sections of the State.

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There is need for more local responsibility for the provision and care of children with rheumatic fever and congenital heart disease. The service should be integrated with the public school system and other local agencies.

The Illinois Heart Association is cooperating to help with the rheumatic fever program, but we are hampered through the lack of public health services.

Delabeling Cardiac Children

I might give you just one illustration of the work that is being carried on for children with rheumatic fever. We have one chapter in St. Claire County that has been very active for the past year and a half. I think some of the greatest

benefits that have come from that clinic were the delabeling of children with heart disease.

We have found that many of the children who have been restricted in their activities—there are some children of high school age who have been kept out of athletics because of a previous diagnosis of heart disease—when examined by a panel of pediatricians and internalists, showed no condition which required restriction of activity.

We feel that these clinics serve a twofold purpose:

1. To prevent children from participating in activities who do have rheumatic fever and congenital heart disease.

2. To delabel children restricted because of what was at one time diagnosed as heart disease.

Statement¹ of

DR. ELLA ROBERTS

Medical Director

The Children's Heart Hospital of Philadelphia Philadelphia, Pa.

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Rheumatic fever is by definition a public health problem. We define public health problems as those which affect a large number of people, social and economic factors of which are not within the control of the individual, and affect the individual either in his productive or preproductive span of life.

To illustrate this, in 1951 in Philadelphia there were reported 448 cases of rheumatic fever under the age of 20.

Like all hospitals, we have felt a shortage of nurses and of individuals trained in the management of children. We feel that our services are being used and used very prudently by physicians in private practice and in hospitals by social workers, by public health workers, by school and industrial nurses.

Adequacy of local public health units: Judging by referrals, this service is adequate. There has been no lag between the development of disease and application for care in our institution. Such a lag we feel might illustrate lack of referral service.

Cause of Rheumatic Fever Unknown

Let me preface this by saying that no one yet knows the cause of rheumatic fever or the cure of

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

this disease in its incipency, but in reviewing our last years we feel that the work which has come out of laboratories, clinics and hospitals, including our own medical schools and pharmaceutical research, has improved the management and seemed to reduce recurrences of this disease.

The recurrence rate in Children's Heart Hospital in 1939 was 22 percent. The recurrence rate of rheumatic fever over the last 7 years in our institution has been one-half of 1 percent. Our recent developments of surgical techniques for the relief of the crippling sequelae of the disease have been most promising and have produced actual cardiac rehabilitation.

The degree to which hospitals and clinics meet the existing needs:

For the most part the needs of children and adults are being well met in this vicinity.

We feel that there may be some lack of adequate facilities for adolescents. They are too old and too large for the children's wards and are of necessity placed in men's and women's wards. This is singularly depressing and is a shocking experience for a teen-ager. Extension of complete hospital facilities into the home, as is being done in Philadelphia, meets the needs of some adolescent patients who are noncritically ill.

However, some patients cannot be cared for in the home, and we feel that further service there might be of value.

The extent to which people are able to afford adequate medical care, with particular reference to present health insurance plans and their adequacy. In our experience the community, the family and insurance resources have combined to meet the existing needs of those children with rheumatic fever or rheumatic heart disease.

Statement¹ of

DR. LOUIS B. LAPLACE

President

**Heart Association of Southeastern
Pennsylvania**

One of the greatest medical economic problems in America today is the employment of the physically handicapped.

Its importance is well recognized and extensive systematic efforts have been made to correct it.

The special problem, however, of persons handicapped by heart disease has certain features which require particular attention.

Why Heart Disease Increasing

The number of persons in the United States who have diseases of the heart and circulation is increasing for four reasons:

1. The numerical increase in the population.
2. The increasing number of persons who live long enough to acquire heart disease.
3. The success of present methods of treatment in permitting heart patients to live longer.
4. The failure of present methods of treatment to cure or prevent heart disease except under relatively few circumstances.

Medical research will ultimately evolve successful methods of prevention, if not cure, for the majority of diseases of the circulation, but until then it will continue to be essential, from an economic standpoint, to support a policy of keeping as many heart patients as possible gainfully employed for as long a time as possible. To neglect such policy in regard to the 10 million persons in the United States who have heart disease will incur enormous financial loss to the Nation, not to mention hardship to the individual.

Regarding the type and degree of handicap imposed by heart disease, it is almost self-evident that there is an extremely wide variation between different individuals. The following general groups, however, can be considered and each presents a particular problem.

Wide Variations in Heart Disease

1. Persons who have no heart disease, but because of nervous symptoms or incorrect diagnoses think that they have. Such persons have no good reason for not working in any type of occupation.
2. Such persons who have a very mild type of heart disease but a long life expectancy. Such persons may generally undertake any but the more laborious occupations.
3. Persons who have more advanced heart disease and an uncertain life expectancy. Such persons are almost invariably fit for some non-laborious occupation.
4. Persons who have very advanced heart disease and a relatively brief life expectancy. Most of these cannot work systematically at all, but a surprisingly large number can still undertake

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

some gainful activity of a purely sedentary nature, at home if not elsewhere.

Needless Unemployment

There are a number of factors which result in needless unemployment in these groups. The most common is overestimation of the severity of the heart disease in a particular case by the private or industrial physician. As a result the patient may not only be advised to refrain from work but also frightened to the extent that he becomes scarcely able to work.

Somewhat less frequent, but equally important, is the arbitrary personnel policy of refusing employment to persons with any type of heart disease because of presumed risk of heart failure during work and consequent penalization from an insurance and workmen's compensation standpoint.

The solution to the problem of the employment of heart patients can be briefly stated as one of accurate medical evaluation and appropriate job placement.

Accurate medical evaluation is a matter of education of physicians, especially general practitioners and industrial physicians. Appropriate job placement has three aspects.

Job Placement: Three Aspects

1. A challenge to labor and management to meet the problem in the interest of humanity and national economy.

2. Change in insurance and compensation rules to eliminate prejudice against employment of persons who are potential or actual poor risks.

3. Establishment of agencies or of special policies within existing employment agencies which will aid persons with heart disease to obtain gainful work, either in an organization or self-employed.

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Work Classification Unit

In February 1952, the Heart Association of Southeastern Pennsylvania established a Work Classification Unit for Heart Patients, which operates in the form of a clinic held weekly at the Philadelphia General Hospital. Patients are referred either by their personal or company physician, and are thoroughly studied by a staff of specially trained personnel.

A report is then forwarded to the referring physician, stating the exact diagnosis, apparent life expectancy and the particular types of work which the patient may or may not perform. This service is subsidized entirely by the Heart Association of Southeastern Pennsylvania and involves no cost either to the patient or to the referring company. As in the three other cities where similar clinics have been established, it has proven very successful and a substantial advance in its field.

Clinics of this type, in their present form, are actually demonstration projects rather than permanent organizations. Many of our larger industries have medical departments which are equally effective in the appropriate placement of employees with heart disease. Others, however, fail in this respect, and it is hoped that their development of more accurate diagnostic facilities and a more enlightened personnel policy will be inspired by the example of the Work Classification Unit.

On the other hand, for small companies which have no medical department and for persons currently unemployed, independent agencies for medical evaluation and job placement will continue to be necessary. They will undoubtedly evolve in various ways as experience demonstrates their scope and functional requirements, some as clinics in the larger hospitals and others as clinics subsidized perhaps by private or civic funds.

Education will also remain a matter of continued importance, and to this end the heart associations throughout the country are placing emphasis on the policy of recognizing economic restitution and not merely management of the disease as the ultimate goal of treatment.

Statement ¹ by

LOUIS T. BULLOCK, M. D.

President

California Heart Association

Los Angeles, Calif.

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The California Heart Association in the past year, as a matter of policy, is spending over 50 percent of its income for research to find a means

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

of preventing heart disease. This is real public health. In the past 2 years of our work we have raised over half a million dollars in the State of California, and over 50 percent of it has been spent for research. We hope in the next few years to raise over five times that figure, and the percentage spent for research will progressively increase.

The Heart Association is meeting this need in an efficient way, in the neighborly way, in the American way. We know what is needed to prevent and cut down the frequency of heart disease. We don't need a politician from Washington to tell us that what we need is more medical knowledge. The citizens of California are co-operating with the Heart Association to develop this knowledge.

One of our greatest difficulties in raising the funds to control this great public health problem is the fact that taxes are so high. The cost of living is so high that the average citizen has trouble contributing what he would like to the Heart Association in its attack upon this public health problem. The greatest thing that could be done for the health of California would be to cut down Federal taxes, cut the high cost of living, and allow the citizens to give more money to causes which they feel are close to them.

Inadequacies in Research

It is true that we need four or five times the amount of money that we are raising for research at the present time. But the government is introducing a form of boondoggling in its research. In the Health Department of the City of Los Angeles they are conducting a study to find out how to identify causes of heart disease. We have millions of cases of heart disease, more than we know what to do with already. The need is not to find cases of heart disease, but to find a method of prevention, find a method of curing it after you get your case. That is the true need. That is what the Heart Association is spending its money for research on. But the Federal government, through the Health Department in Los Angeles, is spending thousands of dollars to find new cases of heart disease. It is using methods that are known to be inefficient, and it is using techniques known to be unreliable; it is using tests known to be inadequate. It is spending large sums of money to find the answer to a simple question that

could much better have been answered by sitting on the opposite end of a table with an experienced radiologist just for about 15 minutes. And the radiologists in Los Angeles try to tell them that it is a waste of money. We told them that it was silly.

If that had been money controlled in Los Angeles we would have been able to prevent that waste. We would have gone out and told the public what was happening. But here is a politician in Washington controlling the waste of funds in Los Angeles, and what can we do about it? Nothing. That is typical of governmental research, of the inefficiency and waste which will necessarily result when our money is taken away from us, sent to Washington, somebody in Washington decides all of the ways of spending the money. If the money is controlled and spent at home it will be more efficiently spent for the health of our people.

There is a need for research, but there is need for true medical research and not research controlled by politicians. The stimulation and financing of research, cure and prevention of heart disease is an excellent example of the voluntary mobilization of large groups of individual citizens for a coordinated attack upon the health problems of the community. This is the American way. This is our way. We can solve our problems with our voluntary organizations, and we are doing it. We are making major strides. We are going places. And we are going to do it lots more efficiently than it would be done if the money were to be sent to Washington and somebody in Washington were to decide how to approach these problems and how to keep you free from heart disease.

We are pleased to advise you that more people are dying of heart disease than ever before. That is the situation because we are having more people in the country of the older ages in which heart disease is frequent. The percentage of people dying of heart disease, who are getting to the older ages where heart disease is more prevalent, is a good index of the general health of the public. It is much better to die of a stroke at 90 than have a streptococcus infection at 9. That is what we are attempting to accomplish.

The increase of deaths of older people is causing a problem in the care of the older age group. The chief problem is that the large proportion of our people are faced with such high taxes, and the

cost of living is so high, that they can't put away the money for research and have enough funds to take care of themselves in that old age. This, however, is largely an economic problem.

I present to you the fact that California has no health problems that Californians cannot solve

better than anybody in Washington. With community organizations such as the Heart Association mobilizing our community effort, mobilizing our public in attacking these health problems, California can take care of its own problems, I believe.

CANCER

Statement¹ of

DR. KATHERINE HESS

Medical Director

Philadelphia Division of American Cancer Society

Philadelphia, Pa.

We have three main objectives: those of education, research and service.

* * * * *

Service to Cancer Patient

What I would like to speak about today falls into the third group, that of service to the cancer patient. The problem of care seems two-fold in nature. The first has to do with early diagnosis and prompt treatment. This concerns hospitals almost directly.

The American Cancer Society has no information as to whether this medical need is adequately met or not. The Society itself has radium and radon seeds available for use in cases of indigent cancer. Greater utilization of both these items could be made by physicians in this area if they so desired.

Terminal Care

The second problem which faces the cancer patient is that of terminal care. After the hospital has finished with active therapy the family is asked to take the cancer patient out of the hospital as no beds are available for this type of chronic illness. The patient usually needs daily nursing care and frequently narcotic injections at spaced intervals. This necessitates a member of the family being home at all times. In many instances such a person is not available since it is a matter of economic necessity to be out working. For help in this type of situation the American Cancer Society is constantly being called upon.

During the year 1951 the Philadelphia Board of Health reported an incidence of 7,282 cancer cases with 4,353 deaths in Philadelphia County; of this number 2,276 were male and 2,077 female; 3,746 were white patients and 607 were colored.

A survey made by a group of volunteers from the Philadelphia Division of the American Cancer Society shows 154 cancer cases are being carried on DPA assistance. Another report, submitted by the Visiting Nurse Society, which receives a large grant from the American Cancer Society for terminal care, shows that 3,486 visits were made to cancer patients in the home.

And a third survey by our group of volunteers at Philadelphia General Hospital revealed that they do not usually accept terminal cases.

Their report cites a caseload of 5,000, followed in the out-patient department, with 257 deaths recorded yearly on the in-patient service and 224 yearly on the out-patient service—a total of 481 per year. Other hospitals in this area carry a proportional load of cancer patients, with a large percentage of free or part-pay cases.

From these figures we can only surmise what the total load needing terminal care might eventually be. We know of 250 cases reported by the Visiting Nurse Society; 257 reported from Philadelphia General Hospital and 154 from DPA records; or a total from 3 sources alone of 661 patients, medically indigent, needing terminal care facilities.

The problem is far from adequately met at the moment in the Philadelphia area. Few hospitals will accept any terminal patients. . . .

There are 68 nursing homes in Philadelphia, of which 44 are licensed. Thirty-one state that they will take cancer patients, but to my knowledge none of the licensed homes will take a person having simply a DPA allowance.

Visiting Nurse Society

This then imposes the original problem of keeping the patient in the home. The Philadelphia

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

Division of the American Cancer Society has tried to meet this problem by pioneering and financially helping to support a project of the Visiting Nurse Society in the program for the chronically ill. Under this program nursing service, housekeeping service, occupational therapy, and physiotherapy are supplied. Financially the area covered has had to be quite limited, but where utilized the program has been highly successful.

To augment this program the American Cancer Society has a variety of services including:

- Radium and radon seeds.
- Transportation for therapy.
- Dressings.
- Bedroom needs.
- Hospital needs.
- Narcotics.
- Medical information service.

Because of the large caseload in the Philadelphia area and the inability of our society to meet the need adequately, we feel that facilities should be made available for the hospitalization of terminal cancer patients, supported by the city, State or Government grants, such as is existent for the disease of tuberculosis.

Statement¹ of

MR. HOWARD METZENBAUM

**Ohio State Federation of Labor
Columbus, Ohio**

I appear here today as general counsel of the State Federation of Labor, and rather than speak with you on some of the broader aspects of the number of problems in which we are interested, I thought I would like to inject in the record some of our thinking on the subject of occupational cancer. We think that this is a field which—like the problems of many other occupational diseases—becomes the special interest of labor because it is working people, not management, who are most affected.

Management in the past has shown a mild, if any, interest in the control of occupational cancer. In view of the fact that such an interest was usually only developed under the pressure of publicity given to the occurrence of these often fatal diseases among working men, it has become essential in the interest of workers' health and its safe-

guard, that not only management and its allied interests—public and private—but above all the present and future victims of occupational cancer, the workers, become closely familiar with the facts about occupational cancer. If those on the receiving end of this sad deal are in possession of the available information on occupational cancers and can fully appreciate the implications and possibilities ensuing from the facts, then workers and their representative organizations will be in a position to cooperate fully with all efforts essential for effective control and prevention.

Medical evidence obtained during recent decades has proven beyond any doubt that cancer of many organs may develop in workers as the result of exposures to an appreciable number of more or less well-defined physical and chemical agents produced, used, and handled in many industries and occupations. The very large number of workers who have or may have contact with such cancer-producing agents during their regular work—and not as a result of any accidental contacts or incidents—is indeed evident from a cursory study of a list of occupational cancer-producing agents.

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These cancer-producing agents may act upon the human tissues by skin contact, inhalation or ingestion. An effective cancer-producing exposure to these agents is as a rule a prolonged one extending over months or years. But it does not need to be continuous nor does it have to be present until a cancer becomes apparent. Up to 20 or 30 years may elapse after cessation of exposure to an occupational cancer-producing agent before the specific malignant tissue reaction becomes manifest.

The occupational cancer does not always develop at the site of primary contact, but may occur in a remote organ in which the cancer producing agent is stored or through which it is excreted or passes through on its way of elimination (bone sarcomas of luminous dial painters who ingested radioactive matter which was stored in the bones; cancer of the bladder in dye workers inhaling or ingesting cancer producing aromatic amines, beta-naphthylamine or benzidine, which are excreted in the urine).

Effects Vary

While some of the occupational cancer-producing agents elicit such reactions always or almost always in the same organ or tissues, others may induce a response in various organs depending

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

upon the type of exposure to these agents or the intensity of contact with them

European Countries

Since extensive epidemiologic data on the occurrence and incidence of occupational cancers are practically nonexistent in this country, one must rely for this information on reports from European countries. In England, which has by far the best statistical data on this subject, there are on record some 2,000 cases of tar and pitch cancers of the skin and about an equal number of skin cancers caused by lubricating oils.

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An excessive lung cancer attack rate has been reported by various investigations from this country and abroad to be present among metal workers, welders, metal grinders and polishers, wire makers, tool and die makers, foundry workers, metal moulders, lathe workers, engineers, mechanics, machinists, painters, tar workers, road workers, asphalters, stokers, patent fuel workers, furnace men, coke oven operators, gas house retort workers, and asphalt workers.

Defective Information

The combined lack of adequate and competent legislative and medical attention is responsible for the fact that in this country there exists highly defective information on the epidemiology, types and number of occupational cancer hazards, the industries and specific industrial operations involved, the number and types of workers exposed, and number and types of occupational cancers occurring. There can be no doubt that many more occupational cancers occur in this country than there are recognized and, particularly, are placed on record.

Occupational Aspects Ignored

This apparent absence of occupational cancer hazards in American industries is achieved by several contributing factors. The occupational nature of the cancers occurring among American workers is either ignored by management and its medical advisers or, when recognized and acknowledged, compensation claims advanced by the victims are settled by private agreement out of court. Through this procedure legal precedents and undesirable publicity is avoided, which in its aftermath might bring stricter legal controls by appropriate legislation.

At the present time we are faced with the peculiar situation that a physician must undergo several years of specialized training, pass a rigid examination and obtain a special license to practice medicine before he is permitted to apply agents and devices for medicinal reasons which may cause cancer (X-rays, radium, arsenic, tar, et cetera). The industrialist who produces, uses and handles identical or similar material has no such restrictions and does not have to fulfill any special requirements of competence or knowledge.

* * * * *

Concerted Action To Safeguard

In view of the fact that each year over 200,000 American citizens die from cancer, that many of these victims are industrial workers and that the possible causation of some or many of the cancers to which these workers succumb may be related to occupational agents, occupational operations or industry connected factors of general living conditions, it seems to be imperative that some concerted action should be taken for safe-guarding the health of workers and their families who might become exposed to these cancer-producing agents.

The following procedures are proposed for accomplishing this goal:

1. A special commission for the study of occupational and environmental cancer hazards should be organized and charged with the study of this problem from medical, sanitary, engineering, medical-legal, compensatory, sociologic, and economic viewpoints.
2. Because of the complexity of the problem, the commission should attain independent status and not operate under the direct authority of any existing health or labor agency.
3. The head of the commission and his chief assistants should be appointed by the President of the United States.
4. The commission should establish cooperative contacts with existing Federal, State, and local health and labor agencies, with labor and management organizations and with civic bodies engaged in health and welfare activities.
5. The commission should receive authority to enter plants and to have access to their medical, insurance, and employment records and to receive and request all information pertaining to the nature, production, use or handling of all materials which might be suspected of possessing cancer-producing properties, to collect data on the

type and extent of preventive, prophylactic, sanitary, and medical measures taken in regard to existing or suspected cancer hazards.

6. The commission should have authority to investigate all environmental aspects of industrial cancer hazards relating to pollution of the air, water, and soil with industrial cancer-producing wastes, and the incorporation and use of industrial cancer-producing substances and devices in articles of daily life and for nonindustrial purposes.

7. The commission should study and ascertain the type and adequacy of existing legislation in relation to occupational cancer hazards (working conditions, compensation, enforcement of existing and future legislative measures, et cetera).

8. The commission should make recommendations to legislative bodies for proper action after having established the facts and after having ascertained the nature and practicability of proper control measures.

9. The commission should be instrumental in making available all already known facts on industrial cancer to the various private and public parties concerned with this problem and should see to it that this information is fully and properly made use of for the maximum protection of the workers and the general public.

10. The commission should be the official body for receiving and evaluating the data obtained from a Nation-wide, obligatory recording of all recognized and suspected occupational cancers and their precursory conditions and should prepare the steps necessary for the enactment of such a law.

11. The commission should be adequately financed by Congressional appropriation.

I want to say only in conclusion that appearing in behalf of the Ohio State Federation of Labor although speaking on the subject of occupational cancer, we do want it to be known that we, in the Ohio State Federation of Labor, just as the other large labor organizations in this state do endorse the President's program on the health needs of this country.

I want to say further, just in passing, that we feel that if the medical profession of the great State of Ohio would spend a little bit more of its money in investigation and self-evaluation of the services rendered to its people rather than spending all of its money in propagandizing on

that score, perhaps there might be better use of their funds.

Statement¹ of

DR. HARRY M. NELSON
American Cancer Society
Detroit, Mich.

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In metropolitan Detroit, hundreds of thousands of pieces of literature on cancer are distributed each year. Posters, car cards, exhibits and displays are placed in conspicuous, donated spots to catch the attention and cooperation of the casual passerby. Hundreds of hours of radio and television time have been donated for educational cancer announcements.

This slowly but steadily increasing awareness of the public to the importance of guarding against cancer has created a growing demand for adequately trained physicians. Efforts are being made to make every doctor's office a detection center.

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Physicians and Nurses Needed

One of the greatest needs for serving cancer patients in Detroit is more physicians and registered and practical nurses. Several of our large, approved hospitals which have complete radiological, laboratory and surgical facilities for taking care of all types of cancer patients, have vacant beds—a tragic situation caused by lack of personnel.

The problem of care of cancer patients differs in few, if any, important aspects from medical care generally. It may be desirable to point out that although most parts of Michigan do have a sufficient supply of physicians, there are nevertheless, 12 counties in the State in which there are more than 2,000 persons to each practicing physician. The projected expansion of the medical classes at Wayne University College of Medicine and the University of Michigan might be mentioned as a way of meeting this problem.

Prolonged Hospitalization

In one significant respect the problem of care of cancer patients differs from that of many of the more common illnesses. The need for prolonged

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

hospitalization oftentimes imposes a financial burden on the patient and his family that makes hospitalization in a private institution impossible. Accordingly, many terminal cancer patients must of necessity become city or county charges.

This being the case, it is obvious that the city and county hospitals must be provided with the best in medical equipment and personnel to provide adequate care for these patients. . . .

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Experience has shown that where additional hospital beds must be provided, and nurses are available, there is no reasonable substitute for direct expansion of the present hospitals. The substitution of terminal-care homes, located at a distance, is unsatisfactory. They are more expensive to maintain since it is necessary to keep in this kind of hospital all that is now provided in the general hospital.

Competent physicians who have a selected interest in the various categories of disease should be encouraged, as scientists, to study their special problems through to the end. It seems, then, that it is sound planning to provide two beds in the present hospitals—where we still find so many of our challenging clinical problems—rather than to provide one bed in the general hospital and one bed in a terminal-care hospital at a distance. We should never place an obstacle between the patient and the physician, and distance is certainly an obstacle.

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Rehabilitation of the cancer patient, in most instances, can be accomplished by the same group of technicians which is helping to make useful, active, and happy persons of the polio patient, the spastic, the injured, etc. One of our greatest needs is a central rehabilitation center.

MENTAL HEALTH

Statement¹ of

MR. SAMUEL WHITMAN

Executive Director

Cleveland Mental Hygiene Association

Cleveland, Ohio

Contrary to tradition, very few parents these days harbor dreams of seeing their children become President; but the dream of every parent is to see his child develop into a happy, reasonably adjusted unit who will make a place for himself in society and contribute something to it.

If we are to bring this dream to full reality a number of problems will have to be solved—and not the least of their problems is the problem of mental illness, which is costing the taxpayers of the United States one billion dollars annually. This does not include the estimate of economic loss due to the loss of potential earnings.

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Sooner or later communities become interested in knowing how many individuals are suffering from what kind of mental disorders. This interest is essential if we are to make an intelligent approach to treatment and control of this illness.

Handicap of Inadequate Tools

Unfortunately we are faced with the handicap of not having adequate and practicable tools to measure the incidence and prevalence of mental illness. Proper diagnosis of a single case often requires hours. In diagnosing tuberculosis, the chest X-ray and sputum examination have made possible examination of entire populations. The Wassermann test has helped immeasurably in quick diagnosis of certain venereal diseases. Unfortunately we have not developed any comparable diagnostic devices to help us quickly determine whether an individual has "X" mental disease of the one-plus, two-plus, or three-plus variety.

What we have to depend upon as a measure of the extent of the community problem is the rate of admission to public mental hospitals, and the number awaiting admission to these hospitals.

We realize that the rate of admissions to mental institutions is at best a poor index as to the actual extent of the problem. Increasing admissions may reflect an increase in hospital facilities, improvement in diagnosis, or simply the inevitable concomitants of an aging population wherein we find senile psychosis and cerebral arteriosclerosis.

Although it was recognized by our professional and lay citizens that it was impossible with the

¹ Delivered at the Regional Hearing in Cleveland, Ohio, September 22, 1952.

tools at hand to obtain a complete picture of our problem, nevertheless in 1949 we did make a substantial effort to reduce the area of the unknown by embarking on a study of the cases known to be under treatment and care of medically supervised resources. We also attempted to learn the number of Cuyahoga County residents needing treatment and care. The count was taken for 1 month only—for October 1950. Twenty-one hospitals and clinics, and 31 social agencies participated in contributing information. Private general medical practitioners as well as psychiatrists contributed information.

Thus we became aware for the first time that according to the most competent judgment available, in October 1950, no fewer than 10,438 Cuyahoga County residents were known to be under treatment and care of medically supervised psychiatric resources, public and private.

When we add to this the 2,400 individuals who were conservatively estimated to be in need of treatment and unable to obtain it during October 1950, we arrive at a total of about 13,000 individuals who were known to be mentally ill in our county.

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Shortage of Trained Personnel

Like most communities of this size, we too have the problem of shortages of trained personnel to treat mental illness. This is not a new problem. Any social or health agency can tell us of the difficulty they have had over the past 10 years in trying to obtain psychiatric treatment for a patient.

But it may be significant to mention here that while the population of Cuyahoga County increased but 14 percent over the past 10 years, the number listed as having passed their Board in Neurology and Psychiatry increased from 13 in 1942, to 42 in 1952—over three times the original number. If you add to this 42, the additional 40 members listed by the Cleveland Society of Neurology and Psychiatry in various stages of preparation for their boards, we have currently 82 medical men who are engaged in various aspects of neuropsychiatric treatment and neurosurgery—a substantial increase.

It is also noteworthy here to cite one of Cleveland's contributions to the development of more trained personnel. At Western Reserve University Medical School, the division of psychiatry, organized in 1945, has been engaged in training

more psychiatrists. There are now 12 in training.

Of equal importance is the program in training of medical students throughout the regular 4-year course of study in the emotional and mental problems in everyday practice.

Although we are aware that more psychiatrists are needed to meet even a part of the existing need, nevertheless we believe that reasonable progress is being made, not only in production of trained specialists but in suffusing the general medical training program with a psychiatric point of view. Also the division of psychiatry is succeeding gradually in making an important contribution to the auxiliary fields of nursing, social work, nursery school and parent education and to the field of juvenile delinquency.

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Available Beds

Exclusive of bassinettes and beds for tuberculosis patients, there are about 6,500 general hospital beds in Cuyahoga County. The number of mental hospital beds in Cuyahoga County are about 3,500. . . .

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In addition, there are close to 4,000 Cuyahoga County residents in State mental institutions located outside of the county. This means that for every general hospital bed occupied by a resident of Cuyahoga County, another Cuyahoga County resident is occupying a bed in a mental institution in or outside of metropolitan Cleveland.

Waiting lists accumulated since January 1951, through August 1952, indicate that 205 mentally ill and 26 mentally deficient individuals have been probated and are awaiting admission. Does this mean that we must construct more facilities or does this mean that more should be done to improve the treatment program in State hospitals so as to facilitate early discharge of patients? Probably both.

To ease the severe overcrowding and to provide room for new admissions, physical facilities should be expanded. To what extent? This can only be determined when our State decides what policy it desires to pursue with regard to its program. It must, for example, decide how much it desires to invest in treatment and better care and how much on buildings.

Care of the Senile

Another important factor in the determination of broad policy rests with a clarification of the

responsibility for caring for older, infirm patients who may require nursing care rather than active psychiatric treatment. We believe that this growing problem created by the need to care for senile patients should be given greater attention and study by the Committee on Aging of the Cleveland Welfare Federation and the Cleveland Mental Hygiene Association in cooperation with the State Welfare Department.

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Emotionally Disturbed Children

Cleveland has recently made an effort to face the severe problem of providing adequate residential care for emotionally disturbed children. This problem was drawn to the attention of the Welfare Federation by the Juvenile Court, the American Association of Psychiatric Social Workers and the American Association of Social Workers. . . .

The department of psychiatry expects to allocate 12 beds to children out of its total of 75 when their psychiatric hospital is built. Of course, this will scarcely ease the pressure for this type of facility, but it will provide an opportunity for much needed research and special training of personnel for work with children.

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A Program of Prevention Based on Vigorous Research

Aware as we are of the shortage of trained personnel, hospital and clinical facilities and in spite of our earnest desire to see a much-needed expansion of those, we are convinced that it would be at best a regrettable social, economic, and medical policy to aim merely in the direction of more and more treatment facilities without emphasizing the importance of a program of prevention made possible through vigorous research.

In spite of sporadic efforts which have been made from time to time to obtain more fundamental knowledge about the causes of mental illness, we still do not have the scientific data necessary to prevent this costly disease. It has come to our attention through the National Association for Mental Health that the taxpayers of our country are spending \$1 billion yearly to pay for the consequences of mental illness. At the same time, only \$5 million per year is being spent by both public and private funds on research.

Fortunately the State of Ohio has begun to develop a research program. In contrast with its

former appropriations of \$15,000 a year, the current allocation out of a special revolving fund is \$250,000. One of the research projects being carried on at Columbus State Hospital by Dr. Papes is designed to ascertain possible organic causes of schizophrenia—a disease which costs Ohio \$7,394,000 yearly. This disease costs the taxpayers of the United States \$1 million per day.

The Need To Develop an Educational Program

We do not exaggerate when we express our conviction that the lack of public understanding of this problem has been one of the factors blocking progress in the problem areas mentioned up to now.

Traditionally mental illness has been clouded by stigma, fear, and the dread fallacy of permanence. This is understandable in the light of history. There was a time when mental patients were alternately worshipped, beaten, driven across the county line and subjected to the laws of vagrancy. We can therefore see how much of an advance was created in the early part of the nineteenth century when crusaders like Dorothea Dix sought to encourage State legislatures to build "asyla," havens of refuge, to protect the mentally ill against those who were allegedly mentally well.

In recent years with the advance in psychosomatic medicine, with the increasing results obtained through modern methods of treatment and with the rise of a humanitarian spirit, coupled with a concern on the part of thinking citizens as they watched the soaring costs of inadequate custodial care, the mental hygiene movement developed as a social expression of the desire to deal effectively with the problem.

Here in Cleveland, we have had mental hygiene committees composed of representative citizens and professional people since 1920. In 1943, our community took note of the staggering number of rejections in Selective Service due to neuropsychiatric causes, and viewing with deep concern the shocking state of our mental institutions, our civic leaders decided to form an instrument which would coordinate the effort to grapple with the problem of mental illness.

Starting in 1944, with a full-time paid executive and a board of 24 members, and a budget of \$10,000, this organization, the Cleveland Mental Hygiene Association, has grown to the point where it has a membership close to 500 citizens, and has doubled its staff; it is working cooperatively with

39 major civic organizations which send delegates to our Council for Mental Health.

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In general, we believe that we are making progress not only with regard to the pressing challenge before us, but are ever alert to exploring new needs and new phases of our problem.

We conclude here with a note of real concern about the problems we still must face in Cleveland, but with confidence that there is much that our community has done and much that it can do toward advancing the cause of better mental health.

* * * *

Cost Per Hospital Day for Psychiatric Patient

Commissioner RUSSEL V. LEE. What is the cost per hospital day for a psychiatric patient?

Mr. WHITMAN. The average cost per day I believe is in the neighborhood of \$2 per diem per bed.

Commissioner LEE. What does that include?

Mr. WHITMAN. That includes everything from laundry soap to psychiatry.

Commissioner LEE. Do you care to take on our California load for those prices?

Mr. WHITMAN. I would not like to take the California load. I would like to take the California State Mental Health Commissioner from you.

Commissioner LEE. Did you say \$2 a day?

Mr. WHITMAN. I said \$2 per day.

Commissioner LEE. How can you feed them for that?

Mr. WHITMAN. I do not know how it is done. Every effort is being made to do that. I believe the cost is exceedingly low and that, too, is an understatement, I presume.

Commissioner LEE. What about the program of preventive psychiatry in the State?

Mr. WHITMAN. May I ask for a clarification of the term "preventive psychiatry?"

Commissioner LEE. I refer to the activities of the so-called mental hygiene clinic that was supposed to do what you indicated was desirable in your preliminary remarks.

Mr. WHITMAN. The program of preventable psychiatry is progressing. I do not think it is progressing at a rate that we are comfortable with. I think we would like to see greater progress in that area, but there have been a number of clinics opened and developed through the assistance of the National Mental Health Act contributing

money to the Ohio Mental Hygiene Division, and a number of clinics have been opened within the past 5 years.

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Indications for More Rapid Cures

Commissioner RUSSEL V. LEE. You indicated, however, how niggardly the State of Ohio is in relation to expenditures for the care of these patients. Do you feel, Mr. Whitman, that if we spent more money on more personnel and better care we might cure more people and return them to private life?

Mr. WHITMAN. If we spent more money on personnel and invested more in an intensive treatment program, I agree with you we would cure them faster. I do not think that we have yet caught up with the techniques that science has had to offer. I do not think that we have been able to apply fast enough what science has been able to offer.

I should go back to the question asked previously by Dr. Lee about the cost per diem of caring for a mental patient. Two dollars per diem is the average cost when we are talking about the long-term care hospitals in which most of our mental patients are.

In fairness, it should be said that the cost for caring for a mental patient in a receiving hospital, a number of which have been set up by the State Welfare Department in Ohio, the cost has been running in excess of \$2. I do not know the exact figures, but I imagine that they run about \$8 per diem, which is a bit away from that rather low figure that distresses all of us who hear about it.

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Ratio of Psychiatrists to Population

Commissioner LEE. How many psychiatrists should there be ideally to care for the population?

Mr. WHITMAN. How many psychiatrists should there be ideally to care for the population?

I say that is a question that troubles me. It all depends on what kind of a society we are going to be living in. I do not know what to pretend and say, that we have not yet emerged with a figure which would properly say that we need "X" number of psychiatrists for the population.

The Public Health Service I know has put out a statement that there should be at least one fully staffed psychiatric clinic for every 100,000 population. But as for the actual number of psychia-

trists throughout the population it is a difficult thing for me to answer.

Commissioner LEE. We have the widest divergence of opinion as to how many psychiatrists are needed. From zero to 100,000 has been the range so far.

Mr. WHITMAN. I certainly cannot pretend to be able to present the number of factors that would be involved in determining how many people we need to cure mental illness, when we need to take into consideration so many other factors. There are more things than psychiatry involved in building mental health. While there are so many influences that are at work in the world that influence the precipitation of mental illness, I do not know that all we need is psychiatrists to help the mental health of the population. We need many more things.

Statement¹ of

DR. GEORGE C. HAM

Professor

Department of Psychiatry, School of Medicine
University of North Carolina
Chapel Hill, N. C.

Before we get into psychiatry, I would like to mention what is our concept of mental health, because we all agree that it is much more than what is included under mental health; namely, mental symptoms and illness for which we require hospitalization either in a State hospital or in a private hospital.

We now know that the mind, or the brain, shall we say, is the centralizing or integrating part of the total person, so that a psychosis for which one has to go to a State hospital or go to a private hospital is only one of the ways in which mental illness, or maladaptation, if you will, can disturb the person. Another way is the neuroses, and still a third way, of course, is psychomatic illnesses.

These all are different techniques which the person can use to solve problems of adaptation.

I would like to point out that in the past 100 years biology—namely, physical medicine—has shown tremendous strides. We know that. We see it today. Infectious illnesses are almost a thing of the past. We are left faced with problems of deterioration.

Inner Dynamics in Individual

On the other hand, more recently sociology and sociologists, anthropologists, and so on, have begun to study our social system, so that we have developed on one hand an understanding of human biology, or of human physiology—how the body works, and what makes the body sick physically—and we have studied on the other hand the various social factors and environment. But in between these two, something has been left out.

After all, biology, within the person, interacts with the environment, and the question is, what is the thing that goes on in the person?

Now, that is now known as dynamics, if you will, or motivations, because when we have a biological need, be it hunger or any other need, it leads toward satisfying the hunger. Still biological, it is now changed and involves us in the environment, so that the motivation which drives us towards satisfying biological needs brings us in conflict with the environment. We thus have to understand the mechanisms that go on in the area between biology and sociology.

Personality Development

There is a growing understanding of the science of personality development, and we know that from birth on, at least, if not before, people begin to try to satisfy their biological needs. This puts them in conflict with their environment. When this happens, the person has to form some technique of dealing with a need that is not satisfied. Call it frustration, if you will. Frustration is normal, by the way, but we have to deal with it. Therefore, we make some type of adaptation.

Now, actually, this growing science of understanding of what is going on between the physical person and his environment allows us to understand a great deal more about what makes people sick. Actually a psychosomatic illness, a neurosis or a psychosis can be thought of in one way as a solution, and as a successful solution, to a problem within that person.

It is hard to see this in that way, unless you will accept the fact that when a person becomes psychotic, it is usually found that before his psychosis developed, he was at a point where some type of violent conflict with the environment was about to occur. This conflict could have included killing himself or hurting someone else. His psychosis allowed him to give up this conflict with reality and to create his own reality in which he could

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

project everything, or it permitted him to deal with it in some other way: "He did it. Somebody is doing it to me."

Successful treatment, by physical means or other, will usually bring the person back through this problem to a state you might call neurotic.

Teaching Mechanics of Personality

Now, obviously, everybody knows we cannot train enough psychiatrists in the sense of specialists to treat all of these problems. So what do we have to do? We have to try to train everybody who is involved in dealing with people to understand this mechanism, to know what is going on. It can be taught; it can be understood.

This involves, of course, specifically physicians and psychiatrists as specialists, but it also involves psychologists, social workers, nurses, and all other types of people who are involved—such as teachers in schools, as has been mentioned.

The more one understands what is going on inside a person that leads to his behavior, the more one is enabled to deal with the problem. The analogy would be to send out doctors, as we did in the past, who do not know circulation work. They find people with swollen legs, and they call this dropsy. It is just a name. But as they do not know the mechanism of dropsy, they can only do such things as put on leeches—something to suck out the swelling, and so forth.

Now we know that there are four, five, six or seven specific treatments which will help these people get well.

The same knowledge of the mechanics of the personality, taught to people who deal with personality problems—and that is everyone—will help in using common sense. Common sense can only be used if one understands the situation, and not merely some derivative of it.

Hope of the Future Lies in Prevention

As I said, enough psychiatrists cannot be trained to deal with all of the problems in the State hospitals. You have heard about the problems of personnel. We now feel, however, that many of the problem cases that have developed, which end up in the State hospitals, are the result of maladaptation existing over many years. An analogy can almost be made with the situation of tuberculosis. As you know, not many years ago the solution for tuberculosis was more and more hospitals for people who developed tuberculosis and had to be hospitalized. Today things have

changed. We are beginning to need fewer and fewer hospitals because we are able to prevent the disease through the knowledge of the mechanism of the disease, through better nutrition, and so forth.

I feel that the hope of the future is in prevention. We cannot prevent until we understand what is happening—and until many people understand what is happening. Obviously this means that prevention has to start with children, with infants. The responsibility rests with parents and those who ultimately will become parents—the high school girls and boys.

Somewhere along the line somebody is going to be mentally affected. In other words, it is the coming into new environment which can distort that individual in the first few years of life, so that later on in life he is unable to adapt properly and reasonably within our framework.

Medical Students Oriented in Personality Problems

Therefore, our goal at Chapel Hill is to train all doctors, all medical students, so that they leave medical school—we hope—and their internship with as much knowledge of physiology, if you will, of the mechanisms of the personality development and its pathology—that is, the illnesses of the developing personality—as they have of the body. They will not be psychiatrists. They are not going to treat people specifically. But they will understand what is going on.

They will be able to know what their limitations are and to practice what might be called minor psychiatry. They will take leadership in the community in which they live, with all types of people who will naturally come to them, and who come to them now.

I did not have this training which led me to deal with these problems when I was in medical school. I had to seek it elsewhere afterwards. And that has been true of most of my colleagues of my age in Chapel Hill now.

These young men will start in their first year in medical school, and continue in their second year, in their third year and in their fourth year, to deal with people and learn to understand and recognize the mechanisms we have been discussing here. In that way, we hope that we will spread physicians through the whole State who understand the problems more and who will be able properly to refer them—to catch them earlier, to help advise others,

to help teachers, schools, ministers, and others with a scientific understanding of personality development.

This program we are implementing. The problem, of course, is in getting adequate teaching personnel. That is difficult, but it can be surmounted in time.

Problem of Specialist Training

The next major problem is the training of specialists—residents, they are called—men who have graduated from medical school and had a year of internship.

Today the minimum training requirement of the American Psychiatric Association is 3 years. Actually, training today, if one wishes to be a well developed specialist in psychiatry, will go 5 years and sometimes 6, depending upon the type of treatment that one wishes to practice. But 3 years is a minimum. This runs you right into the problem of money. Money is always a problem—personally, privately, in teaching and in developing anything.

Problem of Facilities and Funds

Second, we have the problem of facilities for training. A psychiatrist today just cannot go to a State hospital and get all of the training that he needs and wants. He must have available wide facilities—penal institutions, hospitals of the State hospital variety, out-patient departments where neurotics and children are treated and where prevention is done. The trainee must deal with the judiciary, with penal institutions, with the church, and so forth.

Now, we are very fortunate, as John Umstead has said, that through cooperation and association, today we are able to form an association in which all of the facilities necessary for the proper training of resident personnel and graduate personnel will be available.

The problem of money is one because of the lengthy training—and also because of another fact. The United States Public Health Service has been trying to help psychiatry, and has made grants to 43 medical schools to help them pay residents. This makes it difficult for other institutions, when the Government runs out of money and cannot give it to the new ones, because the Public Health Service payments have set the level of payment to residents pretty high.

We are going to be able to meet that problem, I think, here through the farsightedness of the group in the State.

Now, the third problem again is getting adequate training personnel for the training of these advanced specialists. This is a serious difficulty. There is a shortage of adequately trained people. They are in great demand. They are in cities, heavily deluged by practice. But I think that the growing medical school and psychiatric training facilities here in the State will allow us to bring in the personnel in time to make it possible to help in training doctors who go out—specialists and residents, and also to help in the training and working with social workers, psychologists, education departments, teachers, and all other people interested in this problem—including public health workers and people interested in prevention and all other aspects.

Statement¹ of

MR. GARDNER BULLIS

**Representing Mr. Chauncey A. Alexander
Executive Director of the California Society
for Mental Hygiene
Los Angeles, Calif.**

This statement is an evaluation of the mental health needs of this area and grows out of the experience of the agency. It deals particularly with the relationship of the Federal services to Southern California problems.

Incapacitating Disorders

Approximately 50,000 persons in California are incapacitated enough through various types of mental illness to require hospitalization. These figures include: 39,925 individuals in State mental hospitals on June 30, 1952 (33,254 in mental hospitals and 6,599 in homes for the mentally deficient); approximately 5,000 in private sanitariums; and approximately 3,500 in Veterans Administration neuropsychiatric hospitals.

This 50,000 figure is a bare minimum indication of the hospitalization problem and should probably be increased by an estimated 20 percent because of such factors as: rapid turnover in hospitals (15,728 State hospital admissions and 14,818 releases) in 1951-52, commitment laws and overcrowding make it administratively difficult to

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

obtain hospitalization; stigma of mental illness or fear keeps many people away from hospitalization.

The fact that the State has primary responsibility for care of the mentally ill is both a boon and a liability. It means that people desperately ill are guaranteed some type of hospitalization which is available on the basis of need. However, because of this singular state responsibility, local communities and the field generally have dismissed consideration of the problem of psychiatric care.

General hospitals in urban centers have not been inclined to broaden their services to provide psychiatric care as an integral part of their medical service. This contributes to the mental illness stigma and forestalls development of psychiatric care. Only 2 out of 60 general hospitals in the Los Angeles County area have psychiatric inpatient units, a total of 24 beds.

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VA Hospitals

The Veterans Administration hospitals, which serve a special section of the community—the veterans—have policies and practices which create some community problems at the local level. Mentally ill veterans receive hospital care if service connected; or, if not, are eligible when beds are available. This means that a certain number of non-service connected mentally ill veterans may receive service from the VA hospital, or may have to go to their State mental hospital.

Since VA hospitals provide generally a higher quality of service, this means a difference in the service given between two separate veterans dependent upon bed availability. Of course, the major answer is to raise the standards of the State mental hospitals. But this problem also reflects on the variable or “stretchable” policy of hospitalization of the Veterans Administration. It would seem that if veterans are to receive VA hospitalization, they should all receive it, and hospital beds in sufficient quantity should be provided.

The Veterans Administration hospitals should also develop a complete and professional after-care service that will enable the proper integration of the patient into the local community.

Two important patient groups should also receive some immediate priority from the Federal services in the stimulation of adequate hospital services: the mentally deficient and the epileptic.

Handicapping Disorders

A major mental health problem is the handicapping disorders which are evidenced in people who are ambulatory in the community, but who cannot function properly in their family or vocational life. This is the group served primarily by mental hygiene clinics.

National American Psychiatric Association standards recommend 1 all-purpose mental hygiene clinic per 100,000 population; but here again empirical experience has made this agency suspicious of this figure. Services have not been readily enough available to test the numbers who would use the service. . . .

The Veterans Administration mental hygiene services have been excellent in quality and have provided valuable training resources. However, a direct problem occurs because the VA hospital facilities do not provide an out-patient service in connection with their hospital units where they could provide for clinic treatment of more severe problems, provide ambulatory shock, and so forth.

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Adjustment Problems

This mental health area of need covers antisocial reactions, conduct and habit disturbances, and sexual deviations. Individuals who are not necessarily severely ill, yet require special services, because of problems of adjustment fall in this area.

This is a difficult group upon which to obtain accurate data, but the extent is tremendous. The problems of delinquency connected with emotional adjustment problems is staggering. The problems of alcoholism are tremendous in scope and are examples of this problem area.

For example, it has been estimated that there are 289,400 alcoholics in California, and an expected 379,100 by 1960. In Los Angeles County there are an estimated 133,600, and a possible 179,000 by 1960.

A sizable proportion of these mental health problems are handled through law enforcement agencies. The personnel in these agencies, police officers, probation officers, and so forth, are in great need of special training. This will contribute not only to their individual emotional adjustment, but enable them to give more skillful service. It is important for the Federal Government to give more leadership and training aids

through the allocation of special funds for this purpose.

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The importance of some special attention to the group receiving aid through Social Security measures should be stressed. In aid to needy children studies have shown cases of the importance of obtaining some counseling or psychiatric care for the children of broken or widowed homes. Funds should be used to stimulate the use of psychiatric consultation and special training of staff in a mental health point of view that will enable them to help in adjustment problems or aid in the referral to a clinic or agency service.

Normal Growth and Adjustment

The problems of mental health, psychiatric or medical care, cannot be divorced from the problem arising in normal growth and adjustment. The successful handling of problems in usual adjustments is the key to prevention of later psychiatric problems. Mental ill health is the major public health problem and, as such, should receive some of the same concentration that has previously been given to problems of physical health.

Statement¹ of

MRS. MARVEL ROSKIN

**Greater Detroit Parents Association for
Mentally Retarded Children
Detroit, Mich.**

You have already noted that the organization I represent here today has a long, descriptive name. Yet it only hints at what it really represents, namely: Mental deficiency.

Mental deficiency defined:

Mental deficiency has been recognized and described in various ways for a great many years. It has too many times been confused with mental illnesses which can be arrested or cured. Mental deficiency deals with an incompleteness of development of mental ability. Medical science has as yet found no wonder drug for this condition. Research in the future may find some of the answers.

Causes of Mental Deficiency

There are many conditions which can lead to mental deficiency. Among the major causes are: infections which destroy brain tissue, abnormal

development, and a general classification of "accidents" to a child which can happen before, during, and after birth. Many conditions of birth produce brain-injured children, Mongolian children, Cretin children and other types of feeble-mindedness. These are the idiots, the imbeciles, and the morons of our population, the number of which in the United States is staggering. Most authorities estimate that one person out of every one hundred is mentally deficient. By this ratio, 1.5 million mentally deficient people of all ages are of our population.

Parents of Mentally Deficient

Who are the parents of mentally deficient children?:

Hereditary feeble-mindedness is not quite as simple, nor as predictable, nor even as frequent as once believed, for these major reasons: (1) many mentally deficient people, especially the lower and middle grades, are physically unable to have children, (2) the mentally deficient as a group do not have large families (3) the children of the mentally deficient do not survive as easily as children of normal parents.

The parents of mentally deficient children almost always fit the normal pattern. They come from every walk of life, from every race and from every neighborhood. They are the professional, the skilled, and the unskilled workers. They may be rich or poor—but still normal parents, who can or who have produced normal children.

Furthermore, they are for the most part good American citizens, wandering in a wilderness of false hopes for their offsprings. Had they known which way to turn for help from society they would have done so. That is why I am here today!

Responsibility of the Mentally Handicapped Child

The mentally deficient child must be accepted in our society for what he is—a child with a physical handicap. A handicap just as real as if his body were deformed, his sight and hearing impaired, or his heart action abnormal. Certainly a mental handicap is as well a physical handicap—but not so easily seen, and recognized. The American people have been called the best informed of all peoples, with a great heart for the underprivileged, but somehow this understanding and sympathy has not extended to their mentally handicapped children.

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

Neglect of Mentally Handicapped

It is well and good that this Nation, State-by-State, has recognized the blind, the crippled and deformed as physically handicapped, and has helped society do something about its responsibility to these unfortunate children.

Yet we have not gone far enough. The mentally handicapped are the most neglected problem group in our national society. No single State has an adequate program for mental deficiency. Some States have programs that can be called good, others bad. Nothing but the barest minimum essential needs are being met in even the best program of any State. The neglect is now showing up nationally.

Michigan is classified as one of the "good" States. Even so, the program here is very inadequate. Michigan's institutional homes and training schools are 25.2 percent overcrowded. One institution alone, built for half the number, has a population of 4,300 and a waiting list of 600, some of whom are farmed out into private boarding homes. If this is good, what is bad?

Children sent by their parents to private training schools and boarding homes are, more often than not, a lifetime-treatment expense that is not always considered deductible from income taxes. I know many parents personally who are paying from \$70 a month for partial daytime care and training to \$250 monthly for boarding-home training. The price goes as high as \$400 per month at one special boarding school.

And please note that institutional care on a State plan is not free to those who earn even low yearly incomes. Therefore, expense and lack of proper facilities and personnel are the causes for hundreds of children to be home-bound.

So you can see that the ramifications of mental deficiency are exceedingly varied. The problems of mental deficiency are greatly in excess of the number we would expect on the basis of the number of mentally deficient persons in our population.

Mental Deficiency—Mental Health Hazard to Families

Mental deficiency is a highly personal problem to those families which have a mentally retarded child as a member of the family group. They try to camouflage the case. They have feelings of remorse and guilt for producing such a child. If, after long suffering, the family finds help from a

partially State-supported measure, it experiences further guilt complexes in sending a child away. Mental deficiency creates within the family where it "happens" a hazard to mental health and family relations.

What Can Be Done

Improvements will be made when States pass forward-looking legislation and appropriate funds to establish central agencies that will better supervise and care for the mentally handicapped. Together they will try to locate each mentally deficient child as soon as his deficiency can be discovered. Diagnostic centers should be able to do more than inform parents of their child's mental disability. They should be able to determine the child's areas of ability and give the whole picture in a kind and understanding way. These central agencies should carry out progressive programs with staffs of qualified and devoted persons who are properly paid by society for their important work.

Over 50 parent groups are now organized throughout the Nation to help with this problem that affects more children than the dreaded infantile paralysis. I said we are out to help the cause. Parent groups connected with institutions are helping the institution directors add simple facilities with which to do a better job. Groups like the one I represent are taking an over-all interest in the problem. Our needs are clinics, special schools, institutions, sheltered workshops, and recreational facilities. We find most dependent on our help now those children who are called "home-bound" . . . We as a parents' group cannot solve even this much of the problem alone. It goes far beyond us—out to society!

Need Much Help From Society

Mental deficiency is a deep-seated "sore" from birth to death. Further advancement of all study, research, and therapy in this area are legitimate needs in a health program for the Nation.

Human beings—even the most limited—laugh, cry, love, and live. Mentally retarded children have the same basic needs as all other children. They need your help.

Professional Information Used:

Writings of Lloyd N. Yepsen, Ph. D.

Speech by Maynard B. Chenoweth, M. D.

Forgotten Children, a publication of the National Mental Health Foundation, Inc.

Writings of Howard A. Rusk, M. D.

The President of our organization asked me to present this since he is unable to be here. I am the mother of a mentally retarded child. I am also the mother of a normal child. You have already noted that the organization I represent has a long descriptive name yet it merely hints at what it represents. I can tell you it is very hard to be the parent of a mentally retarded child. I am sure it is harder to be a mentally retarded child.

As for the parent, it is hard because it presents a great financial burden. It presents social problems.

For our children, those who are on the higher level of intelligence, it presents many problems. They are denied associations largely; they are denied friendship; they are denied recreation; they are bound within their homes and within their families to a great degree.

Certainly there is a crying need for help for these retarded children.

Statement ¹ of

MRS. C. P. PEI

Public Health Committee, Missouri

Association for Social Welfare

Jefferson City, Mo.

Problem of Mental Deficiency

My own presentation is concerned exclusively with mental deficiency and will demonstrate to you the scope of the problem as it confronts thousands of American families and the pitiful lack of assistance they receive from public and private agencies, from the professions and from the communities.

I am no more anxious than any other individual to exploit publicly the circumstances of my personal life, but I feel no hesitation in taking advantage of this opportunity to speak for the thousands of parents and children who silently suffer the effects of public neglect and indifference.

My situation differs from theirs in no other respect than that I am here in a position to lay the facts before this Commission.

I am a person with no family history of mental deficiency, who has suffered from no degenerative diseases or injury from radiation, and yet three out of four of my children—all of them boys—have been mentally defective.

For 14 years I have sought for research and care to meet the problems with which I am faced, and I have found neither adequate nor humane answers to these problems.

I have been to the best known medical centers in the country, to heredity clinics, and to interested private physicians. I have visited public and private institutions and have investigated the resources in local communities. I can say to you with assurance that these problems represent one of the greatest areas of neglect in American life. There is no safety in assuming that my case is an isolated one.

The most conservative estimate of authorities in the field of mental deficiency is that 1 percent of general population is afflicted with this crippling handicap. In certain areas of the country it runs much higher. Persons working in Missouri estimate the incidence in our State to be 2 percent.

37,500 Mentally Defective Born in 1952

Last year, on the basis of these figures, 37,500 children thus handicapped were born in the United States, and 1,860 in Missouri.

Not more than \$75,000 was spent during any year in research on mental deficiency throughout the Nation—or only \$2 for each new victim.

Compare these figures with those relating to polio, that scourge that captures the public imagination so vividly and against whose hazards the parent and child are protected by the generous annual donations of a sympathetic citizenry, by the care and guidance of a well-organized foundation, and by the millions spent in research.

Last year there were 28,500 new cases of polio, and at least \$2,000,000 was spent in research, or roughly, \$70 per new case. And how effectively it has been spent is shown by the fact that only 14 years after the foundation was established a preventative is in sight. Yet the possibility of your child's being crippled by polio is only 1.39 per 1,000, while it is 10 in 1,000 that you might have a child that is mentally handicapped.

Furthermore, there can be little question that in almost all cases the effects of mental deficiency are more permanently crippling than those of polio.

Assume that these 37,500 defective children born last year had instead been afflicted with polio. The Nation would very properly have been aroused by their plight, yet the cases of mental deficiency were not even publicly reported.

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

Scant Research Into Causes

The statements from hospitals and medical schools in this area and from the Superintendent of the St. Louis State Training School indicates that there is scant research being done here as to causes of mental deficiency. This lack is not due to any ignorance of the problem or of the terrible social effects it creates nor to a dearth of clinical material to work with. It is due, rather, to the fact that no grants of money are made for research.

May I repeat Dr. Edwin F. Gildea's assertion that the frequency of discoveries in research is directly proportional to the amount of money expended.

In preparing this report to you, we asked the help of Dr. Lloyd N. Yepsen, Director of the Division of Mental Deficiency of the Department of Institutions and Agencies of the State of New Jersey. Together with a colleague, he worked out an estimate of the sum needed to begin research in the four most important areas of this field—medical, psychological, educational, and sociological and industrial.

\$1 Million Needed for Research

That sum he believes to be \$1 million or \$250,000 in each area separately.

Compare this \$250,000 for research into the causes of mental deficiency with the \$24 million being spent currently for research in cancer.

The lack of research does not merely represent an interesting medical problem. It represents tragedy to thousands of young people who hoped for families and to thousands of children who are born to lead gravely limited lives.

Dr. Yepsen states that only 50 percent of mental defects are known to be hereditary. The misfortunes that have struck thousands of people otherwise well qualified to be parents surely justify an attempt to explore the causes of the other 50 percent.

Extremely Limited Care Available

I wish to state briefly in the time that remains to me the facts concerning the extremely limited care available to these children, but I cannot do so without mentioning an aspect of the problem that perhaps overshadows all others.

In a day in which we speak of an enlightened society, we tolerate and even encourage a stigma against all persons who are mentally handicapped, which tends to reduce their status as human beings

worthy of the concern of society. While the persons at the head of our institutions and hospitals struggle to give adequate care to the patients in their charge, they are faced with public indifference and distaste that robs them of sufficient funds and support to meet even minimum standards.

Our St. Louis State Training School, with an estimated capacity of 525, and with a population of 545, has had no new building additions since 1939, and requests for this and other items have been cut in every session of the legislature.

Though it is designed as a good training institution, it is so overcrowded with bed patients who can never be discharged that it is assuming the character of a custodial institution. Its waiting list is now 214. This means that the average patient must wait over 3 years for admission.

Meanwhile, the cost to communities and to families rises through the presence at home of children who need the facilities of the training school. Moreover, by State law no child under five may be admitted, and there is serious need for a nursery facility.

Because such facilities are lacking and because it is frequently impossible for such children to remain in their homes, either the parents must assume a burden of costly private care or emergency public facilities that are totally unsuited to the care of these children must be used.

Problem of Making Better Care Available

The situation at City Hospital best illustrates this point. There they must, perforce, receive mentally defective infants and keep them until they reach an age to be admitted to the training school. Some of these children remain there for years, receiving crib care and with no opportunity for recreation or training of any kind. The result is that their retardation is seriously deepened and they are uniformly—regardless of what their original capacities may have been—unable to feed themselves, take care of their own toilet needs, or even understand speech.

The hospital authorities are well aware of the results of this kind of care, but are unable to do anything to improve it.

Meanwhile this care, inhumane as it may seem, is costing the public the sum of \$14.52 per day per patient. The facility used could be reproduced only at the cost of \$18,000 per bed.

Compare this with the institutional cost of \$2.56 per patient per day at the training school and ask

yourselves if it would not be better for the State to provide care for such children, especially since it can offer them, with sufficient support, a training program that meets their needs.

The money spent in maintaining good institutions represents real economy and provides help for many children who actually can profit from it.

The time has come to forget the stigma and to stop saying that they cannot be helped, and to remember the words of Christ, who said:

Verily, I say unto you, Inasmuch as you have done it unto one of the least of these my brethren, ye have done it unto Me."

Statement ¹ of

DR. GUY WITT

Chairman

Department of Psychiatry, Southwestern
Medical School
Dallas, Tex.

Needs for Treatment of the Mentally Ill

First, the State of Texas, in my judgment, needs—probably more urgently than any other thing—a change in the commitment laws. We are the only State now that requires a jury. . . . Our procedures here, if you are not familiar with them, are both interesting and horrible.

A commitment procedure in the State of Texas is carried on in the courts under the rules of criminal procedure. Technically, the insane person is required in open court to plead guilty or not guilty of being insane. He is required to sit there in the courtroom and listen to the relatives relate to the jury the embarrassing and horrible details of the manifestations of his mental illness and state to the jury in the presence of the accused that, "I believe my wife or my husband or my son, or whoever it is, is insane and ought to be sent to the State hospital."

Constitutional Amendment

An effort was made 2 years ago to have a constitutional amendment approved by the voters, providing for a change in this commitment procedure. The measure was lost for reasons that I think I know but don't need to go into here.

Now, I believe that one of our outstanding needs is another constitutional amendment to be presented to the voters, and this change in commit-

ment can only be secured in Texas by means of a constitutional amendment. We do have, for your information, a modified form of commitment, known as the "Ninety-day Commitment," a law which provides that upon the certificate of two physicians, each one of whom have examined this sick person within the preceding five days, the probate judge can commit for a period of 90 days of observation or treatment.

At the end of 90 days the commitment is automatically over, and regardless of the condition of the patient, the hospital superintendent is required either to discharge this patient or to carry through the other type of jury commitment, which, through some humane feelings on the part of the powers that be, can sometimes be done without the patient being in the courtroom. That is the best we have now.

So much for that. I believe that is the crying need of the State of Texas in the way of treatment.

Psychopathic Hospitals

I believe the needs of the public in Texas would be better served when and if a psychopathic hospital could be established in close proximity and in connection with each of the two now existing medical schools which do not have a psychopathic hospital. There is one in Galveston. I believe one should be established in Houston, in connection with Baylor Medical School; one in Dallas, in connection with Southwestern Medical College of the University of Texas.

This, on the basis of statistics of experience, would serve these purposes: first, it would ultimately prove to be a very great economy for the State. On the basis of annual reports of the existing State hospitals and of the Galveston Psychopathic several years ago, it was rather clearly demonstrated that a psychopathic hospital—at that time, they were considering 1 of 250 beds which we hoped to establish in Galveston in connection with the medical school—a psychopathic hospital would pay for the construction and the maintenance in a period of 15 years, through the savings of permanent hospitalization in the State hospitals of those patients who were delayed in getting there.

We faced then and face now the reluctance of families to have their loved ones committed. We face the fear of public reaction, disapproval and so on; but it is a very well-demonstrated fact that the length of time patients would have to be kept

¹Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

in a well-conducted psychopathic hospital and in connection with the medical school would mean so much more adequate staffing than the State has ever been able to provide, financially or in manpower. The saving in time our State hospitals and the residency of patients would not only be a humanitarian thing, and in the public welfare, but would actually prove to be a more economical way of handling the State's responsibilities.

Factor of Better Training of Medical Students

The third thing that I had in mind to present today is in this connection: In the awful picture, and looking toward the future, it goes without saying that the better training medical students and postgraduate students can receive or can secure along the lines of psychiatry, the better is the medical profession able to discharge its responsibilities to the public.

More than 50 percent of all the hospital beds in the United States are occupied by psychiatric patients. There is a terrific, painful shortage of psychiatrists, of facilities for teaching in most medical schools, and certainly in ours here and in Baylor in Houston—we are quite limited. So, those two objectives, I think, are closely allied, and together would serve one of the very urgent needs of the State of Texas along the lines of psychiatric therapy.

Statement¹ of

DR. J. W. MURDOCH

State Hospital

Butner, N. C.

The world is faced with a rising tide of population. Whether the incidence of mental illness is increasing or not, the mere fact of the general rise in numbers of population means that there will be an increase in the numbers of the mentally ill in the world.

The problem then arises how best can this be solved by the community? I can only speak from the mental hospital point of view. There are many other aspects to the problem which you have already heard, and others which could be discussed.

The simple obvious solution would be to build new mental hospitals as the increasing numbers demanded. You may realize at the present time a

new mental hospital would cost about \$20 million. How much a new mental hospital will cost in 50 years, I, of course, do not know. I would not be surprised to find that it might be \$50 million.

Is there any way to resolve this problem without the expenditure of too much of the economic assets of the community? . . . I hope I can suggest some ways, which we are actually using at the State Hospital at Butner, by which the burden can be mitigated.

Prompt Treatment—The First Requirement

The first requirement is to give each patient a thorough investigation and efficient and prompt treatment so that he can return early as a functioning economic unit to his community.

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The treatment given should be prompt and thorough and, as far as possible, individual to the patient. During the past 20 years there have been great advances made in the kinds and numbers of treatments made available for the treatment of mental illness. You have all heard of electric shock, deep insulin, lobotomy and many others. They were not in existence when I began work in psychiatry in 1924. There is no doubt in my mind that patients receiving these treatments recover from their illnesses and are able to leave the hospitals earlier than they could in previous periods.

However, it must be kept in mind that psychiatric investigation and psychiatric treatment are very time consuming, so there must be ample staff to give these treatments to the large numbers seeking treatment.

I may say here that at the State Hospital at Butner we have no waiting list for admission to the hospital, but we do have a waiting list in the hospital for those needing treatment and scheduled for treatment. Our attendant staff is 25 percent short of the total, nursing staff is 45 percent short and psychiatric staff 30 percent short. Since the psychiatric staff of the hospital also does the work of the Alcoholic Rehabilitation center, it will readily be seen that the real shortage of psychiatrists is at least 50 percent.

Adequate Treatment Cheaper Than New Hospitals

Adequate treatment is cheaper than building new State hospitals. Bricks and cement can be an expensive luxury. Treatment, relatively, is cheap. Mr. Umstead, our chairman here tonight and vice

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

chairman of the North Carolina Hospitals Control, estimates that if 1 percent of the total cost of of new mental hospital (that is, \$200,000 instead of \$20 million), were spent additionally per year for salaries to get adequate staff throughout the State hospitals in this State, there would then be less need for the building of new mental hospitals. I personally think he is right.

Treatment is one aspect of the matter. It speeds the patient's recovery and means that more patients can be accommodated through a bigger turn-over. It is in this accelerated turn-over that the real gain to the individual and to the community is made.

Problem of Involuntary Committal

There are other means whereby this accelerated turn-over can be brought about. As a second means I wish to bring to your notice the voluntary admission to mental hospitals as opposed to the more usual method of involuntary committal now current.

When the patient is sent to the mental hospital on committal there is very often great antagonism, not only toward those who sent the patient but also toward the hospital and the staff who are trying to help him. This antagonism must be dispersed before the hospital can begin to help more directly. It is a hindrance to treatment. Overcoming this antagonism takes time—time wasted which could be used to better purpose. If, however, we can get the patient to come of his own free will, voluntarily to seek treatment, then no time will be wasted in getting on with treatment; no time will be wasted in overcoming this attitude of antagonism.

There is a provision in the laws of North Carolina for the voluntary admission to a State hospital. The State Hospital at Butner began to accept direct admissions on September 1, 1950, almost 2 years ago. Since that time 1,053 committal patients have been received and 184 voluntary admissions; that is, about 17 percent of all admissions are voluntary. I think this is a very good beginning. Only in two of these cases have we had to resort to committal procedure when the patient gave the legal 10 days' notice prior to leaving the hospital, since we considered him unfit to care for himself or unfit to respect other people.

During these past 2 years I have found that the average stay of voluntary patients who leave the hospital is 1 month and 24 days. Of committal

patients who leave the hospital the average stay is 3 months and 1 day. You can see, therefore, that there is a big difference in time spent in the hospital between these two classes.

I am well aware that these figures are crude and require evaluation before they can be used statistically, but we have had no time to make this evaluation. I am convinced that the corrected differences will not be of very great extent, and that there is a real difference between the duration of stay in the hospital of voluntary and committal patients, the former being greater.

Early Discharge From Institution Advocated

Thorough and adequate treatment and voluntary commitment are two ways of attacking the problem of helping the increasing numbers of the mentally ill. There is still a third way, and I think this is equally important.

I think I am correct in saying that most people who work in mental hospitals tend to be perfectionistic in their outlook. They want their patients to be completely well before being discharged to their homes. I think this is a fallacy. It is far better, once the acute stage of the illness is over and the patient begins to convalesce, that this convalescence should take place in the bosom of his family and in the environment of his own community. The family circle is a much more healthy environment than any institution, however good and efficient it may be.

I am thus a very keen advocate of very early discharge of mental patients. This factor was forced on me by dire economic necessity, 20 years ago, in another part of the world during the depression, and as I found then, as I do now here in North Carolina, that less than 10 percent of those discharged prematurely return shortly either through failure to continue treatment or relapse. I continued the practice as a therapeutic measure and see no reason so far to change my thinking. I think it is unfair to penalize the 90 percent who continue to get well at home by making them stay longer in an institution simply because 10 percent do not continue the improvement that was thought possible. Thus this gives us a third factor in handling the total situation of the increasing numbers of the mentally sick in our midst.

In conclusion, I advocate voluntary admission as being the best form of admission to a State hospital, in addition to thorough and efficient investi-

gation and treatment. And finally, early discharge to complete convalescence where this can best be effected; that is, within the family circle. These measures will result in a very much larger turn-over of patients and there will be less need then for expensive buildings. This will be an aid to all groups in the community whether urban or rural.

Statement¹ of

DR. LOUIS KOREN

Psychiatrist-In-Chief

Wayne County Mental Health Clinic
Detroit, Mich.

What I have to say on this subject comes from knowledge and experience gained as Chief Psychiatrist of the Wayne County Mental Health Clinic. This clinic is a tax-supported agency established by the Wayne County Board of County Institutions on December 13, 1948, to serve the people of Wayne County.

The board recognized that to wait until people were hospitalized before treatment began would never greatly reduce the incidence of mental illness, since a program based on hospital care alone was not oriented toward prevention and elimination of the sources of mental diseases. Hence, emphasis in the Clinic program was on psychotherapy for the less severe forms of personality disorders, promotion of concepts of mental health through community activities and education, research and training of professional personnel.

Economic Status of Average Applicant

From the economic standpoint, who are the people that come to the clinic? Economically the average applicant is a self-respecting, employed native American who is not indigent, except psychiatrically, and who wants to pay for the treatment he seeks but cannot afford private psychiatric care.

This is due to the special economics of psychiatric treatment which, unlike other forms of medical treatment, requires many hours of the psychiatrist's time for each patient treated.

In terms of dollars and cents, this simply means that a psychiatrist must derive his income from a fairly small number of patients as compared with the considerably larger number of patients

who contribute to the total income of other medical specialists.

Obviously then, the cost for each psychiatric patient must constitute a large budget item, so that a man earning an average income may be able to pay for occasional treatment for an ulcer of the stomach, an infected ear, etc., but unable to finance the week-after-week, month-after-month treatment of a psychoneurotic disorder.

Mental Illness—Economic and Medical Catastrophe

Mental illness, therefore, is frequently a catastrophe economically as well as medically; or, if left untreated because of financial inability, it may be equally catastrophic in terms of family discord, job maladjustment or other varieties of interpersonal difficulties. In this respect the consequences of neglect of treatment of mental illnesses have much wider implications than the neglect of physical illnesses in that they produce a far greater degree of social disruption.

Because of these preceding considerations, income limits for eligibility at our clinic range from \$3,000 per year for single persons to \$4,000 for married persons, plus \$500 added for each child. . . . These income figures indicate that the average American is not able to finance privately extended psychiatric treatment. The clinic charges fees ranging from 25 cents to \$5 per hour, with the average fee being about \$1.25.

The Wayne County Board of County Institutions is well aware that the clinic barely scratches the surface of the mental health needs of Wayne County, where one-third of the population of Michigan resides, but the problem is beyond the resources of any single community.

Dismal Situation of Mental Hospitals

Due to my restricted time, I have given only one aspect of the mental health picture, albeit an important one. I could not, however, conclude my presentation without emphasizing that the situation with respect to mental hospitals is indeed dismal.

The over-crowding of these hospitals has forced them to become largely custodial institutions rather than active treatment centers. It is paradoxical, but nevertheless true, that mental hygiene concepts can least be practiced in our mental hospitals, the place where such concepts should be fully utilized.

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

In summary, I believe that the 4 years of operation of the Wayne County Mental Health Clinic has unquestionably shown that:

(1) There is a tremendous need for psychiatric out-patient services at a cost which people can afford.

(2) Existing facilities are dangerously inadequate to meet this need.

(3) There is a critical shortage of trained personnel, particularly of psychiatrists, which will be aggravated by expansion of treatment facilities. This shortage can only be overcome by financing the expansion of training facilities.

(4) An adequate research program cannot be realized under existing conditions of our overburdened facilities.

(5) Mental illness is a medical emergency, the cost of which cannot be met by the great majority of American people. The great shortage of public out-patient psychiatric facilities indicates that this—in contrast to serious mental illness requiring hospitalization—has not been recognized so far as the less severe forms of mental illness is concerned.

Solution Requires Coordinated Attack

Any solution of the problem must consist of a coordinated attack, including conversion of present mental hospitals from custodial institutions into active treatment centers, a tremendous increase of out-patient psychiatric clinics, an expanded training program to supply the necessary personnel, and an adequate research program.

Mental illness has reached endemic proportions throughout the United States, and the problem must be attacked with the same vigor that was used in combatting tuberculosis or stamping out typhoid fever. A mentally ill person is a "typhoid Mary" who infects others with his disease, and it makes no more sense to delay treatment of mentally sick people than it does in any other communicable disease. Any person less than this means temporizing with the problem. The question of cost no longer can be used as an obstacle to solution of the situation.

How can one equate in terms of money the misery of mental illness?

How equate cost with disrupted homes, intra-family tensions, increased industrial conflicts, increase in delinquency and the many ways which people mutilate and destroy themselves and property in psychologically determined accidents?

Were one to convert all this into a statistic, undoubtedly it would come to billions of dollars annually, and the man-hours of employment lost would far exceed the total time lost from employment because of physical illness or strikes. Mental illness may adversely influence all the activities of people.

Because of the severity and geographical distribution of mental illness, local community efforts, although to be encouraged, are unable to cope with this problem—either financially or in terms of proper planning or coordination.

These efforts to be successful must be initiated on a national basis and only adequate Federal aid can accomplish this job. Such aid must be sufficient to achieve the goal of a mentally healthy people, regardless of cost, not for humanitarian reasons alone, but because only a mentally healthy people can successfully solve the many problems which face us as a Nation.

Statement¹ by

KARL M. BOWMAN, M. D.

**Department of Mental Hygiene,
Langley Porter Clinic**

**(Representing National Association for
Mental Hygiene)**

San Francisco, Calif.

The Problem of Mental Illness

One of the principal unmet health needs in this area is adequate provision for dealing with the problem of mental illness. The estimate from the best statistics available demonstrate that about one and a half million persons in this country are suffering from a definite mental illness, and that another one and a half million persons are mentally defective. It is also estimated that 1 person out of about every 20 will at some time during his life suffer from a mental disorder of sufficient severity to require his care and treatment in a mental hospital, and that another 1 out of 20 will suffer from a mental disorder, which although not severe enough to require hospitalization, will seriously interfere with his happiness, efficiency and general adjustment.

At the present time our hospitals for mental disease, mental deficiency and epilepsy have approximately 800,000 patients. This makes up

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

about 55 percent of all patients in all the hospitals in the United States. About 250,000 new patients are admitted each year to mental hospitals, and about 100,000 more are readmitted, making a total of 350,000.

In addition, at least 200,000 persons, including children, receive treatment every year in psychiatric out-patient clinics. This takes account neither of the large number of patients being treated by private psychiatrists nor of those conditions which are a part of a physical illness.

Availability of Facilities

Ninety-seven percent of the beds in the mental hospitals are in Federal, State, county or city hospitals, and only 3 percent are in private hospitals. Three out of every four State hospitals are overcrowded.

As of August 31, 1952, the State of California has 10 State hospitals and 2 institutions for the mentally defective and epileptic, with a total institutional population of 40,017. Of this population, 33,420 are in the mental hospitals, while 6,597 are in the institutions for the mentally defective and epileptic. The mental hospitals are 9.5 percent overcrowded, and the institutions for the mentally defective and epileptic are 18.3 percent overcrowded. The State of California maintains eight all-purpose mental hygiene clinics treating both children and adults.

The State of California does not have adequate psychiatric facilities to meet the needs of its rapidly growing population. It should have more State hospitals, more institutions for the mentally deficient and epileptic, and more out-patient, all-purpose mental hygiene clinics. In addition, there is a serious lack of trained personnel to staff the present State facilities.

There is general agreement that the care of the mentally sick is the responsibility of the State, and all States in this country have accepted this idea and set up State hospitals for the care of the mentally sick. Most States have also institutions for the mentally defective and epileptic, as well as psychiatric out-patient clinics.

Serious Mental Illness Widespread

Serious mental illness is widespread. It is a long drawn out process and the average family cannot afford the type of care necessary if the patient is to have a good chance to recover. This requires an increase of facilities throughout the

country, with the setting up of better programs for treatment in State hospitals and for early diagnosis and treatment in state all-purpose mental hygiene clinics. Since all medicine passes from treatment to prevention, a program of prevention or mental hygiene must be established.

Specific Measures

The following specific measures should be carried out at the earliest possible moment:

There should be a building program to take care of the present overcrowding and to care for the steadily increasing population.

Hospitals must have staffs of a sufficient number of well-trained competent persons to give the best of psychiatric treatment to patient, not merely custodial care. Since there are not enough qualified personnel to supply the needs, special training programs must be instituted to supply a sufficient number of psychiatrists, psychiatric nurses, psychiatric technicians, clinical psychologists, psychiatric social workers, and occupational and other types of therapists.

At the present time the nature and cause of many mental disorders are still unknown, and a very elaborate program of research should be instituted at once to determine the cause of those disorders and to devise better methods of treatment, and, finally, prevention.

A great deal, however, is known and much can be done. A specific program in mental hygiene should be set up for school teachers and for parents. Much preventive work can be done by psychiatric hospitals and clinics giving direct or indirect services to courts, probation departments, schools and social agencies. General hospitals should become general hospitals in fact and should accept mentally sick patients for diagnosis and treatment, as well as alcoholics and drug addicts.

Inclusion of Psychiatric Care in Prepaid Plans

Prepaid plans for medical and hospital care, such as Blue Cross, California Physicians' Service, Permanente Plan, and so forth, should be encouraged to provide for psychiatric care and not to exclude mental disease. The exclusion of psychiatric treatment from prepaid plans discourages the early treatment of mental cases and thus prevents patients from securing treatment at the time when treatment is most likely to result in recovery.

Since the State will eventually have to pay for the cost of most cases of mental sickness, it should

encourage every possible attempt to secure early diagnosis and treatment. As an example of the inadequacy of present facilities, The Langley Porter Clinic, for the fiscal year 1951-52, had 8,602 requests for psychiatric treatment, but because of limitation of space and personnel it was only able to accept 1,109 patients for study and treatment.

Veterans' Hospitals

I would like to add one further comment with regard to veterans' hospitals. The problem there is in part due to serious political interference on the part of Congress, which is not willing to accept the advice of competent medical persons as to where to put its hospitals and how to set them up. The net result is that the hospitals are being built at places where it will be impossible to staff them, and the funds of the Government are being wasted in that manner.

This has been called to the attention of the President and the Congress many times by the medical advisers of the Veterans Administration, and even the high ranking officials of the Veterans Administration, with no effect. The fault at last goes back to the people of this country themselves, who insist on their Congressmen getting veterans' hospitals in their communities, which are not suited for them and where they will not be able to get the staffs for them.

Statement¹ of

DR. EDWIN F. GILDEA

Chief

Department of Neuropsychiatry

Washington University Medical School
St. Louis, Mo.

We actually represent psychiatric education in St. Louis, and we are interested in taking part in trying to improve the treatment and care of the mentally ill patients in Missouri.

The first thing that stands out at the present time in Missouri is that we have slowly slipped to where we are almost at the bottom in the funds appropriated for the care of people with nervous and mental disorders.

That means, unfortunately, that other states are improving more rapidly than we are. So at the present time the 95 percent of people with nervous

and mental disorders who are cared for by state institutions and city institutions received only a very old-fashioned custodial care.

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Custodial Care Being Lost

Now, in St. Louis and Kansas City a little more progress has been made, but we are still predominantly losing custodial care for most of our mentally ill patients. The recognition of the need for out-patient clinics and preventive service and so forth has been very slow in coming, and although in St. Louis we have had small out-patient services for people with nervous and mental disorders, they have never been adequate, and even today we really only have one full-time clinic for out-patient treatment of these patients.

There are a number of part time services that have been set up.

The city of St. Louis, through the health department, and with aid from State and Federal funds, is now operating a mental health clinic, and that is just really a token clinic.

There is the county, where similar developments occurred; and then there is a considerable program on group therapy, which is tied into the schools; and some relationship has developed between the County Health Department and the schools.

Enormous Wall Between Educators and Medical Profession

That is one of the things I would like to comment on—that there is an enormous wall between the educators and the medical profession. You will notice this particularly when you try to develop mental hygiene programs in connection with the health department.

In this city, they refused for some time to take any child in the public schools who was delinquent unless they first went to some other city agency for relief; but now that barrier is gradually being reduced.

Now, our institutions are over-crowded, and that has been repeatedly our theme—that we have been pointing out the need for new facilities. The State's building program is certainly at least 20 or 25 years behind time in catching up with this over-crowding.

No Facilities for Emotionally Disturbed Child

Now, the care of young people is the weakest part of our mental health program. There are no facilities at all for taking care of emotionally dis-

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

turbed children. If a child is very much upset, so that you cannot manage it in an ordinary pediatric ward, it has to be sent to a ward for adults with mental disorders.

We are continually having to turn down cases here of children because there is no place for them to go. That is true throughout the entire State, and it is a remarkable fact that it is more difficult to raise money to take care of children than it is to raise money to take care of older people, and in the case of children with mental or nervous disorders, it is even more difficult, and the total difficulty increases tremendously.

I think I cannot stress the problem of the neglect of children too much.

I might quote from Dr. Karl Menninger who says that the greatest defect in our culture is our cruelty and our failure to care for our children.

The Mentally Deficient and the Epileptic

Now, the problem of the mentally deficient and the epileptics of all ages is equally bad, and for young children that is particularly true.

Now, statistics on this problem are somewhat controversial, and that is because our institutions for the care of the defective and the epileptics is so poorly staffed that they do not have records that really give a picture that makes possible accurate statistics. We have estimates, and our own personal experience is that you cannot get a defective or epileptic child into an institution under 4 or 5 years after you make an application.

Again, the State institutions do not take children, except in rare instances, until they are 5 years old, and the result is that many children do not receive care until they are 10, which is very late to begin the training of a defective child or producing an adequate program for the control of epilepsy.

Behind 25 Years in Application

So, in summary, the conclusion is that we are at least 25 years behind in applying present day knowledge and modern psychology to the care of patients. We do not have the custodial care that is necessary. The institutions are understaffed and overcrowded.

The answer to this problem, of course, is money, but that is only part of the answer, because even if we had the money we would not be able to hire efficient personnel.

So we have to begin at the beginning and expand our training program, and provide stipends

for young people to enter training in this field, and at the same time build up the budget of our State hospitals.

At the present time they run \$2 and under a day for patients, and that is for everything, and you know how much care you can get in a hospital for \$2 a day.

In the St. Louis area, in order to make a beginning in the training program, in addition to the funds that are now expended, we have estimated that from \$500,000 to \$600,000 a year will be needed.

Statement¹ of

DR. ERNEST G. LION

Vice President

**North California Society of Neurology
and Psychiatry
San Francisco, Calif.**

With the advance of psychiatry and the techniques of psychiatry, it has entered more and more into the general hospital field. At the present time many general hospitals have small psychiatric units, where it is possible to conduct short-term treatment.

Short-Term Treatment

There are a number of conditions in which, in psychiatry, there is a need for short-term treatment. Among them we have various infectious types of psychoses, post-operative psychosis, post-partum psychosis. Then we find mental conditions associated with pernicious anemia, also conditions of intoxication, alcohol and bromide, and there are many conditions in which a patient needs only about 2 or 3 weeks of hospitalization.

This short stay has been made possible by advances in the field of psychiatry. At the present time, with electric shock treatment, it is possible for a patient that normally required several months to a year, or 2 years, of hospitalization, to be treated and out of the hospital in 2 or 3 weeks. At the same time, we have techniques such as lobotomies and insulin shock treatment, and many others, all of which are short-term treatments.

In order to take care of these patients on a formal level, one has to proceed with a commitment from a county for the patient to go to a State hospital. Usually that takes 2 or 3 days of detention in the county for a hearing. Following that

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

they are put into a State hospital, and after about 7 days to 2 weeks of observation, the time the patient is completely worked up, their need for treatment no longer exists, and they are sent back home at a tremendous cost to the State government.

Advantage of Treatment in General Hospital

If this same patient were taken care of in the general hospital, where the condition very frequently is initially diagnosed, they could be treated there, be spared the commitment procedure, and, at the same time, effect a great economy both to the State and to the individual, in terms of the transfer condition which makes for a considerable amount of inefficiency.

Many of these people who are so treated are people of moderate circumstances and can ill afford private care. In order to get private care, if they do so, they have to go through a commitment procedure, but usually a private sanitarium is a costly procedure. There are very few psychopathics who can afford it. There are also very few psychopathic hospitals that take care of treatment of these conditions on a short-term basis, and they have a waiting list that many times goes into 2 or 3 months; by that time the need no longer exists for treatment and other arrangements have to be made for these people.

Inclusion of Psychiatric Conditions in Insurance

I think, in order to meet the problem, it would be desirable to have insurance plans on the private basis that include these acute psychiatric conditions. These conditions provide no greater risk than many other acute conditions, and it is only in the chronic conditions where there is really any need for a long-term State hospitalization.

The entry of any official agency or governmental agency of any sort greatly disturbs the patient-physician relationship in the field of psychiatry, which is a very highly personal one. Again and again I see people who have facilities, through the Veterans Administration or other sources, but who, when it comes to a need for psychiatric treatment, bypass that and seek a psychiatrist of their own because they feel that the treatment is of such a personal nature that they wish a physician of their own choice.

Federal Support in Construction of Facilities

If in any way the Government is to enter into any plan to care for this type of patient, it should be not on the patient-physician relationship; it

should be largely in the field of hospital construction, somewhat akin to the Hospital Construction Act. At that level it doesn't in any way interfere with that private relationship.

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Bed Ratio

Commissioner RUSSEL V. LEE. Do you have any idea as to how many psychiatric beds, in proportion to the general beds, would be required for such a program, Dr. Lion? Would it be 1 bed in 10, 1 in 20, or how many?

Dr. LION. I think about 1 bed in 15 would be adequate for that purpose. There are many conditions in which a general bed could be used, but to have a bed that requires special care could be about 1 in 15.

Commissioner LEE. What would be the average length of time that the average patient would stay in such a bed?

Dr. LION. I would say it would be approximately 2 to 3 weeks.

Statement¹ of

DR. W. CARSON RYAN
University of North Carolina
Chapel Hill, N. C.

It is hardly necessary to remind this group that mental health is still one of our biggest, relatively unsolved health problems in the South as everywhere else. The latest figures of the National Association for Mental Health indicate that some 9 million people in the United States suffer from mental illness and other personality disturbances. It still takes about as many hospital beds for mental illness as for all illnesses combined.

After all, there are three stages in any mental hygiene program, it seems to me: hospitalization followed by a prevention program, and, of course, a positive health program. I think the South . . . is endeavoring to do something real in hospitalization for the mentally ill. But we are not doing much on early detection, prevention and on the positive side.

Community Resources Limited

We particularly need in this area means of handling cases of both mental health and mental deficiency at the community level. Here our re-

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

sources are decidedly limited, especially in rural communities. A recent study of the program for the mentally deficient in North Carolina showed that only some 30 children out of 1,400 in one institution were sent back to their own communities each year, whereas in some States where community services are available from one-third to one-half of the institutionalized cases are returned to their own families and communities.

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Proper Training of Teachers

Much more in mental health can be accomplished in schools than has been generally understood—especially if schools recognize the fundamental task they have of helping children and youth in promoting everyday healthful living. Dr. Alan Challman once said:

There are a vast number of ways in which mental health may be improved, but I believe that in a democracy the most basic of these and the one which must carry the leading role is found in our school system.

A quarter of a million teachers in schools in the Southern States are in touch with children every day and could do much for better personality development and human relations if they were adequately prepared to do it. But they need the help of child guidance clinics and well qualified social workers in doing the job.

Particularly important is the proper training of teachers in child growth and development. We are getting more and more of this in the South, but the public and Boards of Education need to understand how important this is in the daily work of the schools. More and more mental health principles are getting into our teacher-training programs, but here again the rural schools suffer. . . .

Provision for Early Childhood Education

Another real lack in the South that definitely affects the mental health situation is provision for early childhood education. We still have few kindergartens and nursery schools, even in cities and towns, and practically none in the rural areas. It is not generally understood that these programs for younger children have values not only for the children themselves, but, particularly in the case of the nursery school, values in parent education that are highly important for mental health. There are, admittedly, special difficulties in getting these provisions into rural communities, but

every possibility with respect to them should be explored.

Basic for any real accomplishment by the schools is in their acceptance of a broader function for education than has been traditionally assigned to it. Our present-day teacher training institutions are doing much more than they formerly did to prepare teachers to understand that the real fundamentals of education are not the three R's (important as these are as tools), but learning how to live.

The real fundamentals have to do with basic human needs—in health, both physical and emotional; in social and civic understanding and practice—learning how to get along with people; in the fine arts—music, painting, sculpture, drama, and the rest—where some of the most significant mental health and personality development are involved; these are the real essentials. More and more teacher-training institutions are preparing teachers to do these things. And we have to consider the importance of those in selecting people for teaching.

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A Case in Point

There is one historical example that I ran across in my study of mental health and education for the Commonwealth Fund some years ago that I think illustrates the possibilities of what the right kind of schools can do for mental health.

Back in 1914 the woman principal of a large elementary public school in Locust Point, near Baltimore, Md., in the course of health studies she was making came to the conclusion that she seemed to have an abnormally large number of difficult and backward children in her school. Johns Hopkins University nearby was developing its psychiatric program and its first work in intelligence measurement, and members of the staff came to this school principal's assistance.

After a very thorough and painstaking study the survey staff found 166 children who, they considered, were so mentally backward or so unstable emotionally that they could not possibly adjust to modern life. For these children it was prophesied that they could not succeed economically, that they would be always dependent; that they would contribute unduly to delinquency, crime, and prostitution.

Seventeen years later it occurred to someone to try to find out what had happened to these 166

children, now grown to adulthood. Most of them were located. They had not been dependent economically—quite the contrary; although it was the period of financial depression, there were not as many of these persons on relief proportionally as in the general population of Baltimore. They had not contributed unduly to delinquency, crime, and prostitution. Indeed, they seemed to have made reasonably normal adjustments.

What had happened? The answer was in the school. When this woman principal found out what the situation was she had gone to work to make the school over in terms of the real needs of all the children, including these “difficult” ones. She had made the school a center for the mothers of the community, with a milk station, library, and other facilities. She had revamped the curriculum, putting in vocational activities for the older youngsters. She had introduced a more flexible plan of grouping by needs, abilities, and interests. And above all she had used every effort to secure teachers for her school who were “friendly, understanding, human.”

And when Dr. Ruth Fairbank made her final report she said that it was to these teachers, more than to any other factor, that this notable change had taken place, whereby what seemed to be most unpromising human material had been adjusted to successful living.

When we can do it to children like that, we can do it to others.

Statement ¹ of

DR. ROBERT C. PRALL

Assistant Director, Child Study Center

Institute of Pennsylvania Hospital

Philadelphia, Pa.

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The Child Study Center is a psychiatric treatment facility in Philadelphia with a three-fold function.

First of all, treatment of emotionally disturbed children and their parents.

Second, research.

Third, training of personnel including social workers, psychologists, and child psychiatrists. The Health and Welfare Council's Report indi-

cates that the shortage of child psychiatrists presents a constantly pressing problem and even if all the funds necessary for children's service were available, the personnel in this field could not be secured.

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Reason for Shortage of Psychiatrists

I would like to try to explain some of the reasons for the shortage of child psychiatrists at the present time.

First, I feel that the dearth of applicants for training in child psychiatry is in part explained by the needs of the military services, which are claiming many of the young doctors out of medical school and internships.

The American Association of Psychiatric Clinics for Children, who serve as a clearing house for applicants for fellowships for training in child psychiatry, recently stated that in the whole country they have had only 20 applicants for fellowship positions, of which there are many more positions available.

Consequently it has been difficult to find suitable personnel to fill the fellowships which we have available in our training center as well as in other training centers.

Stipends Too Low

I think another reason for the dearth of applicants for training in child psychiatry is the stipend available for such training.

As you may already be aware, our clinic is supported by funds from Public Health Service and State funds as well as by private foundation funds.

The fellowship level, the stipend for the first year is \$3,000, and the second \$3,600. This makes it very difficult for desirable and well qualified applicants to seek training in child psychiatry. I can speak personally, having just survived a 2-year period of training in child psychiatry that has been somewhat of a sacrifice. We know many individuals who are well trained and who would make excellent candidates for child psychiatry training who feel unable to do so because of their family necessities. We might note in passing that many more medical men are married in medical school now than was previously the case, making it necessary for men to have an adequate income in order to pursue the study of psychiatry.

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¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

Continuity in Support Necessary

Our support so far has been year by year from State, Federal, and charity sources. We feel that increased Federal and State funds are essential in carrying out the clinic work, and if possible these funds should be over a longer period and not contingent upon passage of appropriations since this makes planning of the clinic program, appointment of staff and securing fellows extremely difficult, since we do not know how much our budget will actually be.

Consequently we should like to urge a plea for continued help, and we appreciate the Federal help we have already been offered and would like to enter our plea for continued help over a long period of time in order to continue this essential work of training child psychiatrists in order to try to meet the tremendous demand for such personnel.

Just one other point that I would like to make. So far, city funds are not available to us. The Community Chest is unable to accept any new members to give funds to because they already have too many demands on their budget and city funds are not available.

So we rely upon private foundation funds—and they plan to support us through the period of establishing this relatively new clinic and then they will turn their funds elsewhere so we will have to have additional funds.

Facilities Needed

One final word: I should like to emphasize the need which I am sure has already been stated by others and which is pointed out in this study of psychiatric facilities for children in Philadelphia, Delaware, and Montgomery Counties (which has already been submitted by the Health and Welfare Council to your Commission), and that is for the need of facilities for these children.

That is, residential treatment center. We find a tremendous lack of facilities for treatment of children in an in-patient setting and funds will be necessary to support such a program.

For example, this past Pennsylvania legislature failed to appropriate funds for conversion of Oaklawn and Colony Hospital from an epileptic colony to epileptic care for children.

The establishment has no facilities whatever for in-patient treatment. This is urgent and we feel Federal and State support for such a program is essential.

Statement¹ of

FRITZ REDL

Professor of School of Social Workers

Wayne University

Detroit, Mich.

The Mental and Emotional Health of Children

* * * * *

To understand better the incredible inadequacy of Children's Services in the State of Michigan it might be worth while to point to one relevant statistical item:

"The State's birth rate has increased from 99,000 in 1940 to 160,000 in 1950; to 171,000 in 1951.

Expenditures for the needs of children have in no way matched this development. That, of course, is an understatement. Items selected for this 10-minute list:

Lack of Trained Personnel

A nearly fatal lack of trained personnel, especially where the lives of children already vulnerable in the line of mental health are concerned.

For instance: Most of the people who play an important part in the life scene of children in institutions, especially detention homes, reformatories and so forth, are professionally untrained, and even in-service training is either nonexistent or woefully inadequate.

Specialized services, such as counselling, parent consultation, guidance, and so forth, often go begging for want of trained personnel, even where the community in question is aware of the needs of such services and their qualitative improvement.

Some of the causes of this calamity to be attacked:

The financial burden on young people who enter the field, or on other older people who want to acquire professional training after some experience, is too great to afford a 2-year professional training program during which they have no other source of income. Schools and universities are equipped to offer such training, but do not have sufficient financial support for scholarship arrangements.

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

Where scholarships or Federal aid is made available, this is usually tied to the topnotch niches only, such as "psychiatric social work" or the like. Hundreds of well-trained children's workers are needed who would not fall under this specific label, even though well equipped with psychiatric information during their training.

There is great need for organized recruitment as well as interpretation of the importance of the auxiliary professions—nursing is a parallel in the straight medical field. Instead of glamorizing and publicizing the importance of the well-trained child worker, the public sees fit to make the social worker the No. 1 scapegoat whenever scapegoat production seems indicated for political football reasons.

Facilities for Institutional Care of Children

The facilities for institutional care, especially for children with problems such as delinquency, mental retardation, emotional and other disturbances, are woefully inadequate and the situation borders, in spots, on the unbelievable.

Just a few spotlights for illustration:

Only 11 of the 83 counties of Michigan in 1950, did not use jails for the detention of children under 17.

Institutions for the so-called feeble-minded or delinquent have waiting lines so disastrous, that even children processed and well known to be in immediate need of such care have to be left uncared for in their communities for months on end. The same inadequacy also causes institutions to speed their turnover, with the result that poorly rehabilitated children are sent back to their communities prematurely.

There is an over-all recognition for the need of children's psychiatric hospital, which still is not being built, even though funds and plans are available.

Even with the completion of this hospital, a number of smaller and specialized treatment homes will be needed to take care of the variety of disturbances which one hospital facility cannot possibly encompass in its design. There are not even plans as yet under way to fill such a need.

Exclusion From Developed Facilities

Thousands of vulnerable children in our communities are, if not by design, then in practice, excluded even from those services which we have

had the wisdom to develop for the mental health of youth.

Reasons for this exclusion are primarily:

Inadequacy of clinics, consultation services, community centers, special schools, visiting teachers, etc., to take care of the number of children who need such services; many of our child guidance clinics have long waiting lists.

Ostracism of children with adult-uncomfortable symptoms.

You may need camping, even though you wet the bed or have tantrums or a bad vocabulary. Yet, most of our camping services exclude children with more serious problems, who are the very ones who need such services most.

Inaccessibility of services—for geographical reasons, or for reasons of lack of neighborhood understanding.

Example: Travel time to get to Child Guidance Clinic three times a week and having to be taken by parent with car—

Among the most ostracized and neglected groups:

- (1) Children of migratory workers;
- (2) Negroes;
- (3) Girls;
- (4) Children in the 9-14 age range.

Demonstration Projects Needed

There is a need for demonstration projects and practice geared research.

Research in general is encouraged, often privately or federally financed. However, communities cannot afford and agency heads do not dare to create the type of framework which you need in order to do practice geared research. Agencies are afraid of the accusation of high per capita costs, which are unavoidable.

The community provides X-ray machines, hospitals with fully trained staff in the medical field. Research then can easily be built into such institutions.

The communities do not provide equally well designed and well staffed institutions for the treatment of delinquents; without them, treatment methods cannot be studied and experimented with.

You can't do atomic research by just adding a few theoretical physicists to the payroll of a strawberry jam factory.

Statement¹ of

KAY SEAVERS

Chairman

Cleveland Branch of Association of
Psychiatric Social Workers
Cleveland, Ohio

Psychiatric social workers who work in direct and responsible relation with psychiatry, in hospitals, clinics, or under other psychiatric auspices to serve people with mental or emotional disturbances are important members of psychiatric teams, each usually working with a psychiatrist, a psychologist and a psychiatric nurse, and progressive psychiatrists depend on them to assist in obtaining developmental histories and in the understanding of disturbed people.

Because of their special training and interest, psychiatric social workers are keenly aware of the needs in the mental health field, of the efforts and changes that have taken place in meeting needs, and the wide gaps which remain to be filled. Thus far, because of the dearth of workers, only emergency needs have been met on a partial basis.

Few Psychiatric Social Workers

In Cleveland, as elsewhere, there are very few psychiatric social workers in mental hospitals, and most of them joined the hospital staffs within the last few years.

In the Cleveland area, there are approximately 3,375 patients in mental hospitals. Many other individuals, severely disturbed emotionally, known to social agencies, are in need of psychiatric services. Where agencies have the benefit of psychiatric consultation, psychiatric social workers are needed to assist them in obtaining histories of the emotional illness and in working with the disturbed individuals and their families.

There are long waiting lists of emotionally disturbed children who need the services of psychiatric social workers in Cleveland Guidance Center and in other children's agencies. There also are the court settings: Juvenile Court and Criminal Court, where there are too few psychiatric social workers; Court of Domestic Relations and Probate Court, where there are none.

There are approximately 45 trained psychiatric social workers in the Cleveland area. This num-

ber includes 35 who are members of the National Association of Psychiatric Social Workers. The supply here and elsewhere never has been sufficient and community service, therefore, has been greatly limited.

The United States Public Health Service has figured that, for an adequate mental hygiene program, the long-range goal should be: 1 psychiatric social worker for 10,000 people, which would mean 16,000 psychiatric social workers for an estimated population of 160 million in 1960.

1,800 Members in Association

At this time there are approximately 1,800 members in A. A. P. S. W. This association stemmed from a club of psychiatric social workers which was organized in Boston in 1920. In 1926 there were 99 members and in 1949, 1,150 members who qualified by training and experience.

Reasons given by some authorities for the undersupply have included prejudice against psychiatric social work, low salaries in some centers and lack of training facilities. The National Mental Health program of the United States Public Health Service and the Veterans Administration supervised field work program have done much to stimulate interest in this field and to encourage training for it.

Statement¹ of

MRS. VAN HOOK STUBBS

President

Texas Federation of Women's Clubs
Wortham, Tex.

I should like to explain, first of all, my approach to the subject: It is neither professional, nor is it technical. The members of the group which I represent, the Federation of Women's Clubs of the State of Texas, are primarily homemakers, and so, from the point of view of the homemaker and the home and community, I approach the subject of mental health for teen-agers.

* * * * *

Now, since we approach it from the point of view of homemakers, because that is what we are, we have analyzed the situations in our homes and in our communities, and we find that we as individuals and we as study groups have found three glaring mental health needs.

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

¹ Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

Insecurity of Teen-agers

Now, the first mental health need is one that each of us who directs the affairs of a home can do something about. We know that at the pace at which we live nowadays, our homes are beset with hurry, with frustrations and with a multiplicity of duties. And so there is the tendency on the part of the teen-agers in our homes to feel somewhat a sense of insecurity, perhaps, and perhaps a sense of not really belonging. It is a horrifying thought not to belong actually anywhere, or to anyone. Easing this insecurity is one of the needs in the field of mental health that we of the Federated Clubs of Texas have found is prevalent.

We have talked to experts in the field of mental health. Dr. Jackson has helped us a lot in formulating a program that we expect to present to the women of Texas on the first day of September. We are suggesting two remedies in the home that will help overcome the feeling of insecurity and the feeling of not really belonging.

Organization of a Family Council

The first of these is the organization of a family council at a particular time, which must come, if your council is to be held, once a week or every 2 weeks; it must be at the same day and the same hour, a time at which of necessity every member of the family can be present. And there, the problems which are common to the family as a whole, and those problems which are individual problems also, will be discussed. If they cannot be solved at the first session of the family council, a committee can be appointed to bring in data for the solution at the next meeting.

Now, this is a council which has particular rights, the rights of those who are 12 and those who are 16, and those who are 40 and those who are 40-plus. Each one has his rights and each one his responsibilities, and yet, all must act as a unit.

* * * * *

We have also offered a second solution to the family council for making the teen-ager feel that he actually belongs and to make him feel secure; that is, in advocating that our members establish what we call a family ritual. This means doing a certain thing at a certain time, until eventually this acquires a rightness in the home. A code of ethics is established. The family ritual is not some formal organization as is the family council, but it serves a very definite need. It goes

into the field of hobbies, into the field of family devotions; it is a thing that must be done at the same time and the same place all the time; and that gives a feeling of unity and security.

Teen-age Participation in the Community

The second need—and I have spent too much time on the home, because that is where I live and what I love—but the second need we have found for teen-agers is that they must feel they belong to the community and it belongs to them. We are urging the formation of community councils comparable to the family councils and, of course, a teen-ager will belong to the community council.

The survey is made as to what facilities are available, and then these facilities are used. We have a tendency today, since there is much so-called prosperity among us, to just go out and buy what we need. But there is no particular satisfaction in buying; there is more satisfaction—and certainly it is more conducive to mental health—to build and provide with your own hands the things that you need in your communities for wholesome recreation.

Problem of Alcoholism

Now, the third problem we found in the need of mental health programs for teen-agers arose as a result of many letters we have received—some are on expensively perfumed stationery; some come to us written in pencil on ruled tablet paper, asking us, "Can't the Federated Women's Clubs of Texas do something about the problem of alcoholism?" And because of this request, which comes from all sections of Texas, we are trying to provide accurate information and proper mental health for our teen-agers toward the solution of this great problem, which certainly is a mental health problem.

You drive down the highways and look at the advertisements. It is not the ugly woman advocating whatever slogan they use, but the pretty woman and fine looking man. And who broadcasts the ball games your sons and daughters hear in the afternoon? Well, I listen, and it is Falstaff—and then, we hope through educational kinds of program to provide the proper mental health for our teen-agers!

* * * * *

Summing up the problem which the women's clubs in Texas have: We want to meet the need of mental health in our own homes by making the members feel secure and that they belong. We

want to satisfy the needs of teen-agers in the community adequately so that there will be the proper attitude toward the community—"I belong to it and it belongs to me." And then, in the third place, we hope to have a correct mental attitude toward the problem of alcoholism.

Statement¹ of

MISS VIRGINIA HUFFSTETLER

Consultant in Pupil Personal Service

Texas Education Agency

Austin, Tex.

A youngster has the right and a need to expect from a community an understanding of a program of prevention in mental health. Most of us in our communities are working hard at establishing child guidance clinics; we are working hard at obtaining family service units, child welfare units. But in few of our communities do we look at and take time to talk about, to write about and to think seriously about this program of prevention.

Of course, one of the key institutions in any community that is going to deal in prevention will be the public schools, and that is the organization within the community to which I'd like to direct your attention.

The Teacher's Understanding of Behavior

As a youngster enters our public school, he has a right, first of all, to a teacher whose own mental health is good or sound. He has a right to a teacher who is understanding of mental health, a much greater understanding than most people in our profession have at the present moment; a teacher with ability to discern—or at least recognize—symptoms that might indicate the need for psychiatric service; a teacher who would know that she is not able to render such service, but who would be able, by observing, working with and living with that youngster in a classroom from day to day, to know that something was lacking in his behavior which indicated the need for psychiatric services; a teacher who has an understanding of behavior that really enables her not to pass over lightly, as many of us in the past have done, the youngster who needs help the most.

But in addition to this regular teacher we are talking about, this teacher who has a background in mental health that is going to enable her to be a

part of this broad program of prevention, the youngster has a right to special services in the school. He has a need for the services of the school nurse, a school nurse who is interested not only in physical, but also in mental health. He has a right and a need for the services of a well-qualified, well-trained visiting teacher. He has need for the services of a counselor, a person qualified and trained to work with him, still in a program of prevention; a person who can be of service both to the family and to the school, as they work and live with this child.

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Statement¹ of

HON. JOHN W. UMSTEAD

**North Carolina Board of Hospitals Control
Raleigh, N. C.**

The Biggest Problems That Confront Us

There is in North Carolina the tendency to discontinue the county home as an institution in the county. It seems to me that there also is a growing inclination on the part of certain people in North Carolina to disregard the obligations to members of their own families, and try to impose that obligation, if there is a county home, on the county home, and if not, then on us.

As a result, I think that I am safe in saying that we have 500 people in our four mental institutions today who are not mental cases, who should have never been in a mental institution, but who were sent to us when they became a bit of a nuisance around some home, or around some county home. As a result we not only have the State of North Carolina pay more for the keep of the mental institutions than should be paid, but we are taking away from those people who should be treated for mental disease a bed and space that should be theirs.

So when any of us help some kind friend to get committed to the mental institution of the State—some poor old man or some poor old lady, who has become perhaps a nuisance around the house, let us remember this: We may be doing what we think is a favor to that particular person, or persons, but at the same time we are depriving some poor mental patient of the care—and perhaps the cure—that he deserves under our present setup.

¹Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

¹Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

POLIO

Statement¹ by

BERNARD A. EHRENREICH

Executive Director

St. Louis and St. Louis County Chapter

The National Foundation for Infantile

Paralysis, Inc.

St. Louis, Mo.

I almost feel as if I did not belong here, because we do not seem to have many problems. At least, we do not have problems that cannot be licked by the combined efforts of the community—of the magnificent medical profession in this community and hospitals—because, together, the problem of polio in this community has been handled extremely efficiently.

* * * *

The St. Louis Chapter provides the following services for poliomyelitis patients—and may I add at this point that they include all patients, all races, creeds, and colors. Our hospitals, or at least one of our hospitals, the White Hospital, takes in all patients, Negroes included.

Services

The chapter checks with St. Louis hospitals each day to obtain the names of new patients and immediately contacts the patient's family with offers of financial help, if necessary, medical guidance and information.

An interview is arranged with the family to obtain required information and to explain the services which are available to them through the chapter. The chapter provides financial assistance in whole or in part, as circumstances direct, for:

a. Hospitalization for acute and convalescent care, and later for surgery.

b. Medical care for the acute and convalescent stages of polio which require the services of several specialists.

c. Physical therapy and rehabilitative care.

d. Orthopedic appliances, including braces, crutches, wheelchairs, etc.

e. Orthopedic surgery.

f. Transportation of the patient from his home to the treatment center and home again by means of a transportation pool of four automobiles.

During the acute phase of care the chapter, in addition to providing the cost of hospitalization as needed, provides any necessary equipment, including respirators, hot pack machines and extra nurses.

Continuing Responsibility Assumed

The Chapter's Medical Advisory Committee has taken the position that this organization would not operate on a hit or miss basis. It was determined that the chapter would assume a continuing responsibility to make sure that all polio patients that require our services or help would receive every necessary assistance and should be brought back as quickly as possible to a useful place in society.

Thus, the chapter has taken the initiative in making sure that patients receive all possible follow-up care to the end that the maximum rehabilitation might be reached as quickly as possible.

* * * *

This is the experience of the St. Louis Chapter:

(1) There is a shortage of nurses, particularly nurses who will handle polio cases.

(2) Chapter experience with the public health departments of the city and county have been very satisfactory.

(3) It is our understanding that the Foundation's national research program is in a very promising position.

(4) Local hospitals have adequately met all of polio needs from the standpoint of hospitalization and rehabilitation.

(5) Our experience is that most polio patients cannot afford adequate medical care if there is a catastrophic disease like polio in the family.

The chapter's work is supported solely by the March of Dimes.

I might add that we have been able to do our job through the combined cooperation of the public, through the medical profession and through other civic organizations. At this time we don't feel that we have any problems that we cannot lick through that continued cooperation.

¹ Delivered at Regional Hearing in St. Louis, Mo., September 15, 1952.

TUBERCULOSIS

Statement¹ of

MISS PANSY NICHOLS

Executive Secretary

Texas Tuberculosis Association

Austin, Tex.

Provisional figures for 1951 reported by State Department of Health reveal a tuberculosis death rate in Texas which is exceeded by that of only 8 other States. The rate in 31 States is less than 20, and in 16 of these States the rate is less than 15 per hundred thousand population. The tuberculosis death rate in Texas is 24.8.

In 1951, there were 1,962 deaths from tuberculosis reported in Texas. The number of new cases reported was 4,415. Texas ranked forty-eighth among the States in the ratio of new reported cases per death. Any student of the subject will agree that this does not mean we have a lower incidence of tuberculosis than other States. The ratio of new reported cases per death for the country as a whole, in 1951, was 3.8. The ratio of new reported cases per death in Texas of 2.3 is simply an indication of incomplete reporting.

Now that reportable tuberculosis cases have been defined on a national basis, the Texas State Department of Health has set up machinery whereby the reporting in this State can become much more meaningful, provided the established criteria for case-reporting are used by everybody.

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According to a recent report of the National Tuberculosis Association, as an average between one and two new active cases are being found per 1,000 adults X-rayed in mass case-finding surveys. To estimate the prevalence of tuberculosis, the National Tuberculosis Association points out that to this number there must be added those patients already under treatment, some among the group of persons who did not attend the survey, and a very small number of cases among children.

The result indicates that approximately three to four active cases of tuberculosis per 1,000 adults exist as an average throughout the country.

49,000 TB Cases Need Supervision

When this proportion is applied to Texas' adult

population of 4.8 million people, the estimated number of active cases in this State falls between 14,000 and 19,000. Applying to Texas the criteria used by statisticians of the United States Public Health Service and the National Tuberculosis Association to arrive at the number of active cases of tuberculosis in the country as a whole, we find the best available estimate of the number of existing active cases in Texas is 16,000.

On the basis of mass survey findings throughout the country, 7 inactive cases of tuberculosis are estimated to exist per 1,000 adults. Applying these figures to Texas, the total estimate of inactive cases is 33,000. Thus, on the basis that the National Tuberculosis Association arrived at its estimate that 1.2 million Americans need some medical supervision for active or inactive tuberculosis, we can estimate that 49,000 Texans need some medical supervision for active or inactive tuberculosis.

Since the provisional tuberculosis death rate for 1950 in Texas was 26.0 per 100,000 population, the 1951 rate of 24.8 represents a continued decline in mortality from the disease which is comparable to the decline in the country as a whole. Some medical authorities state that this decline throughout the country in recent years is due to the increased use of excisional surgery and chemotherapy; others believe that the decline has to do with lessening of tuberculosis infection.

Whatever the decline in mortality in Texas or elsewhere, the fact that, according to estimate, 49,000 people in our State need some medical supervision for active or inactive tuberculosis poses a sizable problem. With the better case-reporting that we hope for in the next few years, the problem of tuberculosis in Texas can be more specifically defined.

Facilities Shortage

At the present time we know that we are far short of many of the facilities essential to adequate control of the disease, although within the past few years some encouraging progress has been made toward the attainment of certain of these essential facilities.

Texas has 29 microfilm units being operated by health departments and voluntary tuberculosis associations. Of this number, five are available year-round from the State Health Department,

¹Delivered at Regional Hearing in Dallas, Tex., August 18, 1952.

and one from the Texas Tuberculosis Association is available to communities without mass case-finding equipment of their own. The balance of these microfilm units are operated by health departments and tuberculosis associations at the local level.

Since 1946 all but 22 of our 254 counties have had mass X-ray surveys, and many counties, exclusive of those with their own case-finding equipment in continuous use, have been surveyed at fairly frequent intervals.

Intensive Follow-Up Needed

While many cases of hitherto unsuspected tuberculosis have been discovered by these case-finding surveys in Texas communities, a better job of follow-up of persons, with "findings" on the microfilm, would make the surveys more effective.

A number of factors have mitigated against such follow-up, one being the lack in so many communities of tuberculosis clinics where persons unable to afford private diagnostic services can go for examination and medical advice. And in communities where diagnostic and treatment clinics do exist, the number of public health nurses, whose services play such an important part in getting tuberculosis suspects and contacts into these clinics, is grossly inadequate.

Beds Needed

Until recently the minimum standard of beds needed for tuberculosis patients was generally recognized as 2½ beds per annual death; the recommended standard was 3 beds per annual death. These standards have been considered inadequate for some time, and studies are now being made that will probably result in the adoption of a new standard, presumably not to be based entirely on tuberculosis deaths, but preferably on the number of known active cases.

Texas has never met even the old minimum standard of 2½ beds for each annual death and, despite the addition of 1,795 beds in 2 State tuberculosis hospitals established in 1948 and 1949, respectively, we still need over 1,000 more beds to meet that standard.

At present we have 3 State tuberculosis hospitals, 11 other public institutions providing for tuberculosis, and 7 private institutions. The total number of beds in all of these institutions is 3,876. The number of beds in our 3 State sanatoria is

2,554. This leaves 1,322 beds in the other institutions, and certain county sanatoria are not operated to capacity at present, due to inadequate appropriations. These figures are exclusive of 775 beds in 4 Federal hospitals for tuberculous veterans. On July 31, 1952, there were 230 patients on the waiting list for admission to our State sanatoria.

Personnel Shortages

Our State tuberculosis hospitals are handicapped by their inability to obtain the services of a sufficient number of qualified personnel in either professional or nonprofessional categories. This is due, in part, to inadequate appropriations for salaries, but it is also due, to some extent, to poor living accommodations and to the fact that our hospitals are located a considerable distance from the nearest town.

Discharges of patients from our State hospitals against medical advice are somewhat high, but the AMA rate has decreased during the past year. It could probably be further decreased with the addition to the hospital staffs of the necessary complement of medical social workers, occupational therapists and rehabilitation counsellors whose services, along with those of physicians, nurses and other personnel, are needed to provide acceptable standards of patient care.

In a recent article, "The T. B. Picture Today," Miss Mary Dempsey, statistician of the National Tuberculosis Association, made this statement:

The curious assumption on the part of some people that tuberculosis is no longer a major health problem in the United States today is not only at variance with the facts, but is downright dangerous.

Statement¹ of

SIDNEY J. SHIPMAN, M. D.
President
National Tuberculosis Association
San Francisco, Calif.

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The fact is that there are probably about 1,200,000 tuberculosis cases in all stages of the disease in the United States today. Roughly 400,000, or approximately a third, are active cases. About a third of these active cases (150,000) are unknown to health authorities, and thus constitute the chief source of future infection.

¹Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

These are the cases, and those that arise from them, that must be found if tuberculosis is really to be brought under control.

It is true that case-finding has made great strides in recent years. In 1950, 15,000,000 small film X-rays were taken in the United States. Partly as a result, 121,000 new cases were found in 1950, an average of $3\frac{1}{2}$ cases per death.

This means, therefore, that old standards calling for $2\frac{1}{2}$ beds per death are far from enough. Using the old standards, it is estimated that over 32,000 new beds are needed in the United States. New standards which are urgently needed and which are presently being developed will at least double that figure.

Since the advent of miniature chest X-ray equipment and its public health use in 1943, a vigorous tuberculosis case-finding campaign has been waged in California by the Tuberculosis Associations in every county and by the health departments in some areas.

These screening surveys have been conducted among apparently healthy adult groups to find those individuals needing further clinical study. . . .

Findings have varied somewhat, as would be expected, but the average of one new case per 1,000 X-rays has become a fairly accurate measure. This average was borne out in the large survey held in Los Angeles in 1950 in which 1,725,766 individuals were X-rayed.

Case Finding Program

The experience of these past 8 to 10 years has taught us much. The unmet need is to activate an aggressive case-finding program among those individuals seeking medical care for reasons other than tuberculosis. In a study conducted by the California Tuberculosis and Health Association in 1950, it was found that only 24 hospitals in California out of a total of 348 were known to have routine chest X-ray admission programs.

Since that time numerous other hospitals have set up such programs, with results indicating three to four times more positive findings than in mass X-ray surveys. This case-finding technique should be initiated in all hospitals and expanded into out-patient services and private medical study. . . .

Hospital Beds

As has been indicated, the full benefits of a program to eradicate tuberculosis can be more fully

achieved when an adequate number of hospital beds are available for the treatment and for the isolation of those who have tuberculosis..

Official records show that in July 1952, California had a shortage of 1,680 tuberculosis hospital beds in private and public institutions which are inspected by the State Bureau of Hospitals.

* * * * *

A standard based only upon the number of deaths presents a fallaciously low estimate of bed-need because in the past ten years (1941-50) the actual number of tuberculosis deaths in California decreased 44 percent. On the other hand, the actual number of new cases reported has increased 11 percent.

New Drugs Lengthen Hospitalization

With the advent of new drugs, more cases of tuberculosis are living longer. However, this factor necessitates a longer period of hospitalization. For the United States the average stay of a tuberculous patient in the hospital has increased from 164 days in 1940 to 308 days in 1951. It is a reasonable assumption that the experience in California would be substantially the same in view of data available from a few California hospitals.

At the present time, training in tuberculosis nursing is not required by the Board of Nursing Examiners in California. There is need to develop training affiliation programs in tuberculosis institutions for student nurses, as well as in-service training programs for nursing personnel now on the job.

With the advent of B. C. G. vaccine, nurses can be provided protection against infection and thereby alleviate much of the fear of caring for tuberculosis patients, one of the outstanding factors in the shortage of nurses in tuberculosis service. . . .

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Nonresident Patients

In the State of California, where the population has increased 53.3 percent in the last 10 years, and with continuing annual population growth, there is an urgent need for a realistic approach to medical care of nonresident patients. Naturally this factor varies widely in different areas in the Nation, depending upon available facilities and shifts in population. This problem involves the development of means for reciprocity between counties and states for the care of tuberculosis

patients not having established legal residence, but who, by the nature of their disease, present a public health hazard.

Development of Social Research Program

After almost 50 years of experience in tuberculosis control measures, it is generally recognized that medical management alone cannot eradicate tuberculosis, because of the many inherent psychological and social characteristics which accompany the disease.

Concurrently with a needed stepup in medical research, there is the need for the development of a sound social research program to determine the extent of social and environmental factors in the care of tuberculosis patients.

Rehabilitation Service

The need for rehabilitation services from the point of diagnosis to the point of return to useful living is recognized as a basic service to the temporarily and permanently handicapped people, including the tuberculous. There is need for expansion of these services, including prevocational and vocational counselling, education, retraining and placement of more tuberculous patients to prevent breakdowns and readmissions.

The need for acceptance by the employer of arrested tuberculous patients cannot be too strongly stressed. As the incidence of tubercu-

losis is increasing among men over the age of 45, the need for these services is accentuated.

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Future of Vaccination Program

Commissioner RUSSEL V. LEE. What about the future of vaccination programs? We have had a great deal of emphasis in WHO and other organizations of that kind.

Dr. SHIPMAN. I suppose you refer to BCG, Dr. Lee, and in certain areas in the world BCG, this *Bacillus-Calmette-Guerin*, a vaccine, is the only method which can be reasonably used to control the disease effectively, because there are no sanatoria or very few sanatoria in which people can be put.

The control by vaccination leaves much to be desired.

The Commission which I spoke of as acting for the National Tuberculosis Association says that the other theoretical possibility of a quick end to the tubercular problem would be the development of a completely effective and entirely harmless vaccine. But despite a tremendous amount of work on this problem throughout the last half century, such a suitable vaccine has not yet been discovered, and there is no reason to believe one will be developed in the near future. However, BCG has a certain place in certain areas with certain groups.

BLINDNESS

Statement ¹ of

DR. LORAND V. JOHNSON

**Clinical Professor in Ophthalmology
Western Reserve University
Cleveland, Ohio**

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We wish to emphasize that Cleveland is the typical American city with a medical center which provides limited but excellent facilities for the use of their teaching staff of physicians. It is beyond the financial capacity of these medical centers to provide laboratories for research in the blinding eye diseases or complete institutional facilities to supply the community needs for therapeutic and diagnostic care of potentially blinding eye dis-

ease for either private or dispensary patients. . . .

We wish to emphasize that a program for the prevention of blindness must be supported by funds from outside interests. The University alone cannot maintain these facilities for the complete care of the community.

The Economy in Prevention

Probably these sources must be those which have currently underwritten financial support for the care of the blind, and we wish to give figures to support the contention that it is uneconomic for our Government, as well as private agencies, to ignore the fact that prevention is cheaper in dollars than support and rehabilitation.

The Perkins Institute for the Blind and New York Institute for the Blind each has an endow-

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

ment fund in excess of \$8 million. The income alone from either fund represents a larger sum than the endowed resources of all of the ophthalmologic research laboratories combined. The cost and care of one blind baby through its life is estimated at \$100,000. The total research budget of the laboratory for research in ophthalmology is but \$70,000 a year.

While in this area alone there were, this last year, over 35 babies blinded from one condition alone—retrolental fibroplasia. A recent survey in this State listed the names of over 300 blind preschool children. In the fiscal year of 1952 the State of Ohio alone spent the sum of \$3,222,000 to help meet the needs of the blind, and this does not include the expenses of private agencies.

The total cost of blindness to the greater Cleveland community is over one and a half million dollars annually, a sum with which we pay for nearly half the cost of a modern eye institute with facilities for research in the blinding eye diseases and opportunity for the care of individuals with potentially blinding eye diseases, including charity, private, and industrial injuries and diseases. Over 300,000 blind taxpayers benefit from the \$600 added income tax exemption. A loss of \$180,000,-000 top bracket tax income.

Eye Care for Children

The public schools of Cleveland provide eye care for indigent children in regular and sight-saving classes, but for lack of adequate facilities these services are performed in gymnasiums or classrooms of the public schools, where no facilities are available for consultation or diagnostic work.

The Cleveland Society for the Blind has been successful in coordinating the many social services available in Cleveland, but does not completely supervise this work for any free eye clinic in the city.

Major industry of Cleveland provides for its workers not only industrial, but prepaid nonindustrial sickness and accident insurance benefits, and as a result is almost completely providing for the health needs of its workers and families. In a specialty such as ophthalmology it is not sufficient simply to provide funds for payment of services. It is also essential that the metropolitan community be provided with facilities where these services may be properly performed.

Eye Institute

The creation of an eye institute appears to be beyond the scope of any general hospital in this or other communities. Direct care of the blind costs at least \$125 million each year. Crippling eye injuries cost industry in this country \$200 million each year.

Of this national total of \$300 million, a total of \$2 million would probably represent the cost of care to the Greater Cleveland area, an annual sum which would properly serve to construct and equip a modern eye institute capable of research, diagnostic, and therapeutic studies for preventing blindness, and for the treatment of injuries and diseases of the eye.

Interests broader than those of a general hospital must be available if this great loss in terms of dollars as well as human suffering can be prevented. Even the large teaching hospitals do not feel justified in providing principle or endowment for the maintenance of eye institutes in excess of their requirements for teaching needs. They maintain the position that creation of facilities for research in blinding eye disease, as well as minimum community requirements for diagnostic and therapeutic measures for preventing blindness, must be supplied from those sources which are now rendering social and economic aid to the current blind.

In fiscal 1952 the State of Ohio spent a total of \$3.222 million for aid to the 10,949 blind people on its register. These services are as follows:

- Aid to the blind, \$2,500,000;
- Medical care, \$75,000;
- State services, \$180,000;
- Ohio State School for the Blind, \$265,000;
- Ohio Rehabilitation, \$185,000;
- Rotary Funds, \$17,000.

Expenditures of Private Agencies

These figures do not include expenditures of private agencies in Ohio, such as the Cleveland Society for the Blind, the Cincinnati Society for the Blind; societies in Columbus, Toledo, Youngstown, Canton, Akron, and the Goodwill Industries of Dayton. The Cleveland Society for the Blind had a budget of \$79,000 for social services budget alone.

We find a total of \$19 million of endowed money for the proper care of the blind and observe that the total amount in dollars spent for research in

blinding eye disease in this country is less than the income from one of these endowed funds alone.

Is it not time that our Government draws a grant total of its direct and tax-deductible cost of blindness in this country, and, by direct grant to university medical centers, give financial assistance such as was provided by the Hill-Burton bill, create institutes for ophthalmology for research in the blinding eye diseases, as well as therapeutic and diagnostic ophthalmic care? There is bad bookkeeping when the Greater Cleveland share of the national cost of blindness could, for \$3 million, build for this same city an institute which would greatly reduce this annual expenditure to the city.

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The Industrial Commission of Ohio spends in excess of \$5 billion in the settlement of industrial eye claims each year, and the self-insured section 22 employer spent an additional \$1.7 million.

May I conclude: Is the humanitarian compulsion for the blind so deep-seated that resources will never be available for research in the prevention of blindness?

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Federal Support

Commissioner RUSSEL V. LEE. Who should provide this money, Dr. Johnson?

Dr. JOHNSON. In the complete text of our report we have recommended that the Federal Government supply to each medical center a sum of money not to exceed one-half of its current obligation for the care of the blind for the construction of modern eye institutes, where proper care in diagnosis, surgical therapy, research and other facilities can be provided.

Research and Prevention

Commissioner LEE. How much blindness is really preventable if you had resources to administer?

Dr. JOHNSON. Certainly most of the nonfamilial, nonhereditary types of blindness, most could probably be prevented with better research facilities, better understanding. . . . Conditions such as glaucoma, the unfortunate results following cataract surgery when provided in poor circumstances, iritis, which is the major cause of blindness—these could be pretty much preventable. Conditions such as diabetic retinitis in the near future will probably be preventable. . . . A great deal of this blindness can be prevented.

Commissioner LEE. That all presumes some future research, does it not? In the light of what we know at the present time, are we having much blindness in this area that could have been prevented?

Dr. JOHNSON. It is difficult to estimate how much current blindness in this area could have been prevented. However, in examining eyes of blind individuals one can look back and in retrospect find many who need not have been blind.

Industrial Accidents

Commissioner LEE. How much of a factor is industrial accidents?

Dr. JOHNSON. I believe that about 11 percent of the blind result from industrial blindness. However, that question must be qualified because very frequently a man will lose one eye and continue to be employed, and, then, sometimes, 15 or 20 years later, perhaps through some separate accident, he will lose the other eye. Thus one cannot say that the preventable loss of one eye is totally responsible for the entire blindness.

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National Institutes of Health

Commissioner ELIZABETH S. MAGEE. Dr. Johnson, I would like to ask to what extent are these research problems being tackled by the National Institute of Health?

Dr. JOHNSON. The National Institute of Health, through their Institute of Neurological Diseases and Blindness, are providing funds; and, may I say, most of our funds come from that source. But they do not provide laboratory facilities. They supplied money for personnel and money for materials and equipment. They represent almost entirely the funds for current research in blinding eye disease. I will say the funds are very limited. I believe \$40,000 is the total amount they are spending for the country in comparison to \$150 million our own Federal Government is supplying for direct aid to the blind alone.

Commissioner LEE. What agency should have the authority to spend these Federal funds?

Dr. JOHNSON. It is my feeling that these funds should be provided, such as those funds in the past were provided, by the Hill-Burton Fund where moneys were matched for the creation of hospitals and laboratories where existing facilities were not adequate. So far as blindness is concerned, I feel that a separate bill should be introduced which

would allow similar money in any university center or any center capable of handling these funds properly for the creation of an institute to provide facilities for that entire community.

Commissioner LEE. Do many communities have an appropriate facility to receive such funds at the present time?

Dr. JOHNSON. Such facilities should be available

around any major medical center, whether it be in Cleveland or Columbus or Cincinnati, and it is my feeling that such proximal institutes would completely supply our State with proper facilities.

Commissioner Lee. Do you mean the medical schools?

Dr. JOHNSON. Generally, medical centers are built around medical schools.

CEREBRAL PALSY

Statement¹ of

MR. L. LLOYD

**Representing the National Osteopathic Cerebral Palsy Foundation
Philadelphia, Pa.**

I am going to take but a very few minutes to tell you something of cerebral palsy. Perhaps you know more than I do. I became very much interested in it about 10 years ago, and then I started to do something about it. I tried first of all to find out how many cerebral palsies there were here in my own State, and I could not get any estimates.

Then I went on up into New Jersey, New York and on up into the New England States. There I found the same thing.

Coming back I determined, after consultation with a very close personal friend in the medical profession who had a boy with spastic paralysis, that I would go on down to the South.

And that I did. When I was through I had traveled in 38 States and about 100 different communities within those States.

No Authentic Records Available

I am frank in saying to the Commission this afternoon that in every community in which I went I consulted those in the capitals to find out if they had any record of cerebral palsy, and there were none.

But I also found that I could get no authentic information as to the number of physicians who knew anything about cerebral palsy. I also learned from the heads of several prominent medical hospitals and colleges that most of the information that they could give would be guesswork. They knew no one in their city or town—some-

times I was in a town where there were about 5,000, and oftentimes I was in cities of many hundreds of thousands. I was shocked at the conditions I found, because on my route I had passed through Washington and gained the information, after a week, that there were approximately 250,000 under 21 years of age affected with cerebral palsy.

I had no difficulty in getting into the offices of physicians or into the hospitals in the cities and towns where I traveled. I had no difficulties in getting information from the physicians in charge of the clinical work in all experiences. But nowhere did I find any particular amount of work that was being done in behalf of the cerebral palsy victims.

Use of Braces

Oh, yes, I found many, many hospitals that were using the brace, and by this time my knowledge of some of these methods was pretty good.

I found that where they were using the brace they took a great deal of pride in saying after 1½ or 2 years: "John could walk—at least four or five or six or seven steps."

I looked in many places wherein I found paraplegics braced from their feet to their heads or to their shoulders, and I watched them shuffle along. I watched great gears over their heads come down over their shoulders and catch on to these braces and to this contraption so they might more easily move one foot and then the other by the shuffle method.

I had found some States that had begun to awaken to the seriousness of the problem. I had been in homes where there was a family with eight or nine children—with one spastic lying there—a most pitiful sight, because the income for that family was anywhere from \$40 a week to \$65. This was prior to 1939. I looked over these meth-

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

ods in every community with a hopefulness that somewhere—some place—I would find someone that could help.

Doctors Praised

Now, while I am representing the Osteopathic Institute, believe me, I have no ill will against the medical profession because, first of all, without their help I do not think I would have gotten much of anything.

And let me say to you that I was shocked to hear the address I heard a few moments ago, because I never went into the office of a physician—who had an “M. D.” on his door—and asked him a particular favor—to get a cerebral palsied some treatments or some of the families that were in need—that they did not respond. And they did not make a charge for their service.

Thank God I live in a country where there are men of the type in the medical profession that there are. We may differ as to methods, but I want to say right now that I will take issue with any man who dares to say that the medical profession or any of its branches does not measure up better and finer than any in the whole world. There is no finer.

Clinics Established

And now here in the city of Philadelphia, within the last 2 years, we find that many of our hospitals are beginning to set up clinics for some cerebral palsy patients. We of the osteopathic profession believe we have a method that is good. . . . In fact, we treat quite a number of children whose parents are members of the medical profession, and we are proud of that.

We do not boast about it because, in a cooperative spirit, we know this—that in our lifetime we need medicine. It has brought us a long way. We need the surgeon. We need the dentist. We need the osteopath and we need everyone who is working together for one goal, helping to bring a better life and a life less filled with the agonies of disease—and we have that here in America. . . .

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Cerebral Palsy Needs

Gentlemen of the Commission of the President of the United States, let me appeal to you on three points alone. . . .

What cerebral palsy needs most today is money for research work on what causes cerebral palsy. . . .

Secondly, we need places of treatment, because in my travels over the country I could not find 100 doctors in the country—and this is not said in any way derogatory to them or in a spirit of criticism—but I could find less than 100 of them that could tell me that in their communities there was anyone fit to sit down and diagnose a cerebral palsy case at birth.

But we have come a long way in the right direction. We have organizations working in this city night and day, giving of their time—and you members of this Commission can do a great work if you can just help a little, for we have no funds except the few meager funds that have been donated by public subscription, which do not in any meager way attempt to go into the research work of cerebral palsy.

Hospitals cannot house them, so all over the State we have one institution in Pennsylvania. If the victims become dependent and have to be committed, that is a mental institution where they do not belong.

But that is true since also of many other States throughout the country. True, since I have been back I have heard from Kentucky. They are beginning to do a great deal down there—and in Ohio, and clear out to the Pacific coast. But we do need help on research; we do need places of treatment—better and more expensive than our present clinic system.

We do need places of care for these children, because there are very few places where they can be sent except into an institution for mental retardation. We do not even like to contemplate that happening to children who in many instances are fine, keen of mind, keen of understanding, and wanting with hope in their voice and in their eyes, saying to you, “We believe it can be done.” Living in the United States of America, I believe it can be done, too.

Where else in the world would a President or the head of a Nation take the time out to appoint a Commission to go out over the highways and byways and gather information?

I have been sitting here since 2 o'clock. Your patience has been great; your understanding will be great and the report that goes back into the President's office, I am sure, will bear some fruit in the future, and to those who need it most. Help us, if you can, on the three points; research . . . treatment . . . care.

OBSTETRICAL CARE

Statement¹ of

DR. HAROLD OTT

**Michigan Society of Obstetricians and
Gynecologists
Detroit, Mich.**

The specialty of gynecology and obstetrics which I represent deals with those conditions and diseases peculiar to women and childbirth.

During the last 50 years, and more particularly during the last quarter century, much progress has been made in this field of medicine. The death rate for women during pregnancy and childbirth has become lower than for any 9-month period in the same age group of nonpregnant women, so that, according to statistics, at least, it is safer for women to have babies than not to have them.

Yet however much we may pride ourselves on past performances, we are fully conscious that if certain problems in this field can be answered the lives of many more women would be saved.

Tremendous Strides in Safety

The modern environment of childbirth has contributed significantly to its safety. Transportation and hospital facilities have made available the advantages of trained medical personnel, advanced technics and proper equipment. The ready availability of blood for transfusion and the so-called "wonder drugs" for the treatment of complications has made it possible for the physician

¹ Delivered at Regional Hearing in Detroit, Mich., September 23, 1952.

today to avert what only a few years ago would have been catastrophes.

In Michigan in 1900 there were 452 maternal deaths, a rate of 10.3 per 1,000 live births. In 1925 there were 629 maternal deaths, a rate of 6.4 per 1,000 live births. By 1950, population of the State had increased almost 3-fold, yet only 91 mothers died, a maternal death rate of 0.6 per 1,000 live births.

Having a baby in 1950, statistically speaking, again was 20 times safer than it was in 1900 and 10 times safer than in 1925. This decrease in deaths has come principally from a better understanding of medical problems and the finding of appropriate solutions for many of them.

Studies Valuable

Because maternal death studies have demonstrated their value and effectiveness, a similar study of infant deaths and stillbirths has been started in Detroit. Both the obstetricians and pediatricians believe that despite the many hours which this study will require of them, it will point out means whereby more babies will be able to survive the critical first few days of life. The death of pregnant women as it relates to surviving children has been a research study at Children's Hospital.

Another study at this same institution deals with certain obscure anemias of newborn infants, and also is about to be concluded. These coordinated efforts to define problems and search out solutions will be reflected in the near future in a further decrease in stillbirths and infant deaths.

RADIOLOGY

Statement¹ of

L. HENRY GARLAND, M. D.

**Pacific Roentgen Society
San Francisco, Calif.**

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A radiologist is a physician and surgeon who, following graduation and internship, has had three years of additional training in the specialty. Most radiologists in practice today are specialists

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

examined and certified by the American Board of Radiology.

Radiology: Definition

Radiology is that branch of medicine which deals with the diagnostic and therapeutic application of radiant energy, chiefly in the form of X-rays, radium, and radioactive isotopes. It is largely referred medical practice, patients being sent to the radiologist by their personal family physician or specialist.

Radiologists' Services

The radiologist furnishes X-ray examinations of persons in connection with both preventive and therapeutic medicine. Many also furnish X-ray and radium treatments, and some diagnosis or treatment with radioactive isotopes. . . .

Most diagnostic radiological services are furnished to the public in radiological offices, or in the offices of other physicans and surgeons in which X-ray units are installed. The remainder is furnished in hospital X-ray departments and other institutions.

Radiologists tend to locate, like other specialists, in urban and suburban communities. There are approximately 4,000 certified radiologists in the United States today, or about 1 radiologist per 50 other physicans and surgeons. In general medical practice, in which patients of all ages and both sexes are seen, and in which the very ill, the seriously injured and the very aged are handled along with the ambulatory relatively well person, it is estimated that 1 radiologist can adequately care for 25 patients per day, or 6,000 separate persons per year. . . .

Group Practice

Increasing numbers of radiologists are practicing in groups of two or more and are providing their specialist services, both as part-time physicians in hospital X-ray departments and part-time physicians in their offices. Whether singly or in groups, their services are available to patients at any time, on request of the attending physician.

Costs of Radiologist Service

The furnishing of adequate radiological care requires relatively large amounts of space, equipment and supplies, so that the cost of practicing medical radiology tends to be about three times the cost of practicing other forms of medicine or surgery. By efficient utilization of apparatus and personnel, the cost of providing diagnostic services can be reduced considerably.

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The average payment for radiological services by persons with acute hospitalized illnesses was 2.3 percent of the total costs of the illness in one recent survey. It is reported that radiological services cost the public about \$1 per person per year (all persons considered).

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Adequacy of Radiological Services

Need versus demand! In larger American communities today, the supply of radiological services is believed to be adequate. Persons in need of X-ray examination of the gastrointestinal tract or kidneys can secure such examination in most communities within 24 hours.

Comment on Diagnostic Centers

Those who do not actually practice diagnostic medicine such as radiology, pathology, and similar specialized medical services often believe that these services could be furnished on "line production methods." Indeed, many believe that they could be furnished on a slot machine basis.

Well, between 1917 and 1941 we had an enormous experiment in the United States in the form of diagnostic facilities conducted by the Veterans Administration. Many of these facilities ground out literally tens of thousands of X-ray films, microscopic slides and other technical items per week. However, the problem of staffing the X-ray and pathology departments with competent, interested specialists proved insurmountable. It was common practice for persons who had obtained a "positive" diagnosis at one of these facilities to proceed immediately to some physician in private practice who was specializing in the appropriate field in order to seek confirmation.

It is not believed that diagnostic centers conducted by the State or Federal Government would be efficient or effective. On paper they appear as a sensible plan; in practice they have proved deceptive and inefficient. It is difficult, if not impossible (outside of one unique teaching center), to mass produce a good professional service.

As the Brookings Institute has concluded, the important point is not how much medical radiological service is being rendered to the public, but the type and quality of that service. Quantity without quality is unavoidably wasteful; it increases the chance of erroneous diagnosis. It encourages omission of the regular physical examination. The person who loses most is the sick or injured member of the public.

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Supply of Radiologists

Commissioner RUSSEL V. LEE. Are there enough radiologists at the present time?

Dr. GARLAND. No, it is estimated that this country could use about 5,500 specialists.

Commissioner LEE. And you now have about 4,000?

Dr. GARLAND. About 4,000.

Commissioner LEE. What about the ancillary personnel in X-ray? Our Commission has been told a number of times that there is a great shortage of X-ray technicians.

Dr. GARLAND. In certain part of the country there is a shortage of X-ray technicians. Fortunately, in this State, because of, I suppose, Southern California advertising or other phenomena, there seems to be a surplus. The need is being met in other States by increasing the amount of office training or apprentice training of technicians.

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Training of Ancillary Personnel

Commissioner LEE. That was the next question I was going to ask you. What should be the mechanism for the training of these ancillary personnel that are required in the X-ray field?

Dr. GARLAND. The way it is being handled in this State today is that certain radiologists in private offices and some in the hospital departments will take on an applicant—or anywhere up to six applicants, depending on the volume of work—usually for a 1-year course. Usually the persons are girls or young men who have had a year of college or a high school education. The requirements are rather elementary, and they are given apprenticeship training for 1 year without charge.

Commissioner LEE. Is that meeting the need at the present time?

Dr. GARLAND. It is meeting the need in this State, but I am not sure it is meeting the need in all States.

Dr. SHEPARD. Are they then licensed, or given a certificate?

Dr. GARLAND. No, they are not licensed. They work for radiologists, just like a secretary or clerk works for them, and I am not sure that licensing would improve the quality of the work.

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Coverage of X-ray Cost

Commissioner ELIZABETH S. MAGEE. I would like to ask whether the cost of X-ray work is included in most of your prepaid medical plans? I mean, such as the Blue Cross.

Dr. GARLAND. Well, the various medical plans are somewhat different. In some plans they attempt very broad coverage, but in most plans they have coverage just for the first accident or injury and for all illnesses that require hospitalization.

The great problem that was shown so beautifully by CPS in the first 10 years of its growth is that if there is unlimited X-ray service available in any type of insurance plan—such as we have for example in the Army and Navy hospitals—the abuse is almost uncontrollable, because not only do the public run for an X-ray every 5 minutes, but—I am sorry to say that our own profession is very human and when it is very tired and has 40 patients to examine—they would also order a lot of X-rays if there were no financial or psychological barrier. It is a very badly abused specialty.

Part VI

REBUILDING HEALTH AND USEFULNESS

REHABILITATION

Statement¹ of

DR. LAURENT FORISZ

**Butner Hospital Alcoholic
Rehabilitation Center
Durham, N. C.**

From the over-all point of view, the rehabilitation of the alcoholic could be divided into three fairly distinctly separate phases.

The first phase could be called, according to the common parlance, the sobering up work. This would mean the process of clearing the after effects of intoxication, such as filling up the exhausted vitamin depots, handling the immediate emergencies, including possible infections on account of a decreased resistance of the body, and restoring the normal physiology of the organs—including among others, the treatment of major psychiatric conditions based on impairment of the brain function, such as delirium tremens, et cetera.

Only after this has been completed could anybody come to the second phase of rehabilitation, which consists of investigations into the causes of the drinking habit.

There are many theories and working hypotheses concerning the causes of alcoholism, apparently none of them giving the full answer. It seems to be the most likely though that the cause lies in the personality's physical, mental and emotional aspects.

The ever-broadening evidence seems to point mainly towards the emotional aspects of the personality; therefore, although not neglecting any of the other aspects, the investigation should be focussed on the analysis of character traits, emotional structure, and the developmental phase of same.

It includes a thorough investigation of the patient's social background, the features of the formative years and the later circumstances that seem to be contributory to the actual imbalance of the patient's character structure. The end-product is what could be called the insight material.

This leads us to the third phase of the rehabilitation process, comprising the insight giving and the working through of the problems contained therein, resulting in a personality change that would allow the patient to live his life without the crutch of the alcohol.

Within the framework of the North Carolina Alcoholic Rehabilitation Program, our chief concern is phase number two, and to a lesser extent, phase number three, phase number one being considered as primarily a medical problem that should be taken care of on the local community level.

Not every intoxicated individual is necessarily an alcoholic, and not every alcoholic in this phase of rehabilitation work is a candidate for rehabilitation.

Motivation and Cooperation

Phases number 2 and 3 require, what we call, sufficient motivation and cooperation from the side of the patient, and apparently science or society have not found the answer yet to this very important question of building motivation.

It seems to be the opinion of everybody in this field that voluntary patients offer the best or, perhaps, the only chance at the present time. One of the indicators of adequate motivation appears to be the patient's willingness to contribute financially to his own rehabilitation.

Based on these considerations, the treatment unit at Butner admits voluntary patients only and charges \$72 for the 28 days' stay in the in-patient

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

service. During the 4 weeks, collection of insight material and the initial process of insight giving run side by side.

Through the cooperation of the local welfare departments, in the overwhelming majority of the cases excellent social histories are at hand for the clarification of background material, as well as current patterns of every aspect of the patient's life, sober or drunk.

Group Psychotherapy

During their stay with us the patients are placed on group psychotherapy which is carried out with the help of films about mental mechanisms and other aspects of the problem—serving didactic purposes on the one hand, and on the other hand, giving chances for identification, helping to break down roadblocks standing in the way of emotional learning. To some extent and, in many cases, to significant extent, other factors inherent in the group technique will be used in operation.

Parallel with this, all the necessary medical, laboratory, psychological, and psychiatric investigations are carried out, and the patients are also offered a chance of sufficient recreation, occupational therapy, and spiritual guidance.

It would seem obvious that only a limited number of patients would be able to achieve sufficient changes in their personalities within these 4 weeks to be able to cope with their problems in their personality functioning that would then allow them to live the rest of their lives in sobriety.

"Working Through" Phase

This is the most important reason why the third "working through" phase of the rehabilitation requires outside help for the patient. For some of them association with Alcoholics Anonymous Groups, its group technique and its spiritual aspects, offer sufficient help; in other cases the help of a social worker, the sympathetic listening of a minister and his spiritual guidance might mean adequate support.

In our opinion, in most cases—and in some cases, very particularly so—long-term psychotherapy of some form is indicated, unavoidable or indispensable. This phase, comprising the long-term program, could not be handled in a central place, if not for any other reason than merely the geographical. Other than this, financial, social or other environmental conditions would dictate a decentralization of this branch of the rehabili-

tation, placing the patient back on the community level.

Local mental hygiene clinics seem to be the most appropriate places for this phase of the program. There are several of those in the State, but they are carrying a great case load of other type of diseases.

Enlarging Local Clinics

The North Carolina Rehabilitation Program is putting a great effort into the encouraging of local agencies to make such facilities available for alcoholic patients. Financial support was furnished for similar purposes, allowing the local clinics to enlarge their staff for the same end.

It is felt that sufficient time has not elapsed yet to evaluate the efficiency of our work. The followup of an alcoholic constitutes a separate problem of considerable size in itself. However, the general impression seems to be that the majority of our patients and the general public show satisfaction with our work.

Statement¹ of

MISS BELLE GREVE

**Executive Secretary
Cleveland Rehabilitation Center
Cleveland, Ohio**

Rehabilitation today of course is the concern of all people and all nations. This is evidenced by the number of international and national conferences. More and more people are coming into the field of rehabilitation because medical science in recent years has advanced so much that it is giving life to people who are severely disabled—and giving all of us more life.

There have been a number of changes in this field of rehabilitation in the last 25 years, particularly in the philosophy of rehabilitation. Years ago we felt sorry for people who had disabilities; we felt they should be grateful for anything the community gave them; we felt that they should take any kind of a job at any kind of wages and be glad to get it.

We have changed, so that today we believe every person has a right to the fullness of life; and even though part of a body is damaged he should have the right to live as any other person in the community lives, going to school, going to work, participating in regular community life.

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

Rehabilitation for Living

We have learned, too, in recent years that rehabilitation means more than just being prepared for a job. It is true that at the present time, while medical science may give life to people it is not able to cure many of the things which make a person disabled. Sometimes the extent of the disability is so great that it is not possible for a person to have regular employment in regular industry, and yet he has life before him, he is a member of the family and a member of the community. So rehabilitation facilities today are geared to the idea of having the disabled person live as fully as he can with the full understanding of his capacity.

In Cleveland we are very proud of the fact that we were in the rehabilitation field in the eighteenthies when some private organizations came into the picture. Since that time, as Government agencies have come into the field and as other voluntary agencies have developed their programs, there has developed excellent teamwork and excellent planning among these three groups—Government agencies, community chest agencies and voluntary health agencies.

Teamwork Advocated

The first recommendation therefore which I bring to this Commission is that this relationship of public and private agencies should be strengthened and should not be minimized—that as we go on in our field of rehabilitation it may be necessary to develop new facilities, new machinery. . . .

We like the idea of this teamwork of Government and private agencies. We believe it is the way of life in a democracy. I think that we all admit that we are a Nation of causes, and that we are always sponsoring something which some of us believe is good for some of the people or all of the people.

Because we have this teamwork of Government and voluntary agencies, it has been possible to experiment, and to demonstrate and try new ideas from time to time, particularly in the field of rehabilitation.

Size of Problem

The second recommendation we would like to bring to this group is that we should find out the size of our problem, if possible. We need to know the extent of the problem, how many people of all ages are in need of rehabilitation. We include

the person who is mentally retarded, the person who is mentally ill, the epileptic, the person with heart trouble, the person who is orthopedically handicapped, and so on.

* * * * *

Program of Prevention

We believe that there should be a very extensive program of prevention, something which might be similar to that which has been developed by the tuberculosis organization.

Personnel Training

Then we come to the health recommendation regarding the training of adequate personnel. If we believe that an individual is more than flesh, if we believe that after medicine has given him life he should have a chance to live as fully as possible with his limitations and with his capacities, then other skills are needed to tie up with medicine. We are recommending that there be established in Ohio training facilities for staffs necessary in the rehabilitation program.

We are a great State. We are larger than many nations of the world. Yet we have only two training schools, one for physical therapists—located here in Cleveland in connection with Cleveland's Clinic, where I believe the number of students is 16—and 1 in connection with the Ohio State University.

Now if we are going to give life to people and if we are going to develop more and more hospital facilities, what are we going to do with the people who are severely disabled if we do not have the professional staff necessary for rehabilitation programs?

I was recommended by a special committee of the Ohio Program Commission that there be established two schools at the universities in Ohio which have medical schools—one for the training of physical therapists and one for the training of occupational therapists. The establishment of such schools costs money. We are making the recommendation—we are not suggesting how it be paid.

Facilities for Rehabilitation

The sixth recommendation is that there be developed adequate facilities for rehabilitation services in hospitals, schools and centers, and that these rehabilitation services include physical as well as vocational rehabilitation. We know that

such departments mean adequate equipment as well as adequate staff.

One committee recommends that some of these facilities should be established on a regional basis. We know that there are people in rural communities who need physical rehabilitation. At the present time the Ohio State Rehabilitation Center has 12 beds which may be used for over-night care for people who need a work-out for rehabilitation.

Twelve beds in a State as large as Ohio do not meet the needs. So we recommend the development of facilities on a regional basis.

Cooperation With Industry

The seventh recommendation is that there be established some program of working with industry so that industry can be better equipped to adjust the person who has severe disabilities to jobs. We learned from one nation which reported at the world meeting, that in that particular nation the slogan was, "If you can't change the man any more, change your machine."

So, production should take place through the adaptation of machines to the capacity of the individual. We do not know just how this could be done, but we would suggest that the State Employment Services and their local branches give serious consideration to this type of research in industry.

Greater Placement Facilities

The eighth recommendation I have is that there be developed more extensive placement facilities for people who are severely disabled so that the person with the disability does not have to shop around or agencies do not have to call the same industry. It might be that some central system could be developed under the employment service.

Self-Employment Program

The ninth recommendation is that there be established on a State-wide basis an adequate program for the self-employment of people who are so severely disabled that they cannot leave their homes. We give particular emphasis to the person who lives in a rural community.

The committee suggests that it might not be wise or feasible or suitable to bring from rural communities all the people who have disabilities to any central place, but it might be much wiser to take to them some type of employment. There might be established a State-wide system of training.

Adequate Security

The last recommendation, the tenth, is that during a period of rehabilitation there be adequate security for the person and members of his family.

It is not an easy thing to face a permanent disability, not know how your children are going to eat, and what will happen next.

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Responsibility Designation

Commissioner RUSSEL V. LEE. Miss Greve, I would like to ask you who is to do all this? Under what auspices?

MISS GREVE. We come back to our first recommendation: that the Government and private agencies work closely together in the development of better services or expanded services, and that there be careful consideration as to who should do what.

Commissioner LEE. Federal Government, State government, local governments?

MISS GREVE. There are three governments—Federal, State, and local—there are national health agencies and there are private community chest agencies. So I would think before I would answer any one of them that we would want to study the responsibilities of each. All organizations have constitutions, articles of incorporation—or the Government agencies have—under which they function.

Many times when you sit on a national committee or go to a national meeting you will find that the same law is interpreted different ways in different places. It seems too bad that frequently the same law does not meet the needs of identical people because they happen to live in a different place in the country.

There might be a clarification of some of the laws now on the books. We know in Ohio that our State legislature does not appropriate enough money for vocational rehabilitation, which could be matched by similar funds from the Federal.

I can say to you, we are all working together, the Government and the Chest and the voluntary agencies, to secure a larger appropriation. We know that we need it. As to some of the new things, I would not feel that I was qualified to recommend just how they should be met.

Most of us feel that most of the organizations are already in existence; that most of these new things can be done by adjustments of program and better teamwork.

Statement¹ of

MR. FLOYD KEFFORD

Chief of the Physical Restoration Bureau of Rehabilitation

Pennsylvania State Department of Labor

Harrisburg, Pa.

I represent the State Bureau of Rehabilitation, which has agencies throughout this State performing services necessary to restore a person with permanent disability and an employment handicap to satisfactory employment.

These services may employ medical services, surgical services, hospital services, training prosthetic appliances—whatever is necessary to help that individual regain his economic independence.

Care of Severely Disabled

We enjoy the cooperation of the medical facilities throughout the State, the welfare agencies, tuberculosis societies and all those who are interested in the disabled individuals. We have, however, a problem in Pennsylvania which is growing each year, and it is for this reason that I would like to appear before the Commission—to state the problem. We are in need of a rehabilitation center to take care of the severely disabled individuals in the State of Pennsylvania.

Industrial, medical, and educational advancements in the past 10 years have shown that the severely disabled individual, formerly left to lead an unproductive life of dependency on family or public funds, can now be rehabilitated and restored to a state of independence and employability.

With the facilities now existent in Pennsylvania it is impossible to accomplish this vocational rehabilitation; and an institution designed to incorporate all the required services is urgently needed so that the physical, social, mental, and economical handicaps of these individuals may be eliminated.

The facilities of the typical community, with its crowded hospitals equipped to provide medical and surgical treatment for acute and short-term illnesses, and with its schools designed for the normal nonhandicapped individuals, are not adequate to provide the combined program for services required to rehabilitate the severely disabled person.

For example, existing vocational schools do not offer physical rehabilitation and auxiliary services, nor do the hospitals provide vocational training and long-term treatment for disabled persons. The vocational adjustment of the individuals who must wear artificial limbs, braces, or use a wheelchair, crutches or canes to move about, can only be accomplished by making available in an institution especially designed for their physical needs the various services of physical restoration and vocational education that is required to help the handicapped attain maximum adjustment in the home, in the community and in employment.

Those Unable to Adjust Smoothly

Many of us are familiar with the disabled person who has made his adjustment with his own resources by a fight against overwhelming odds. We are not aware, however, of the large number who are unable alone to make the adjustment, who are dependent, and who present a serious social problem.

Hospitals, convalescent homes, and county institutions have thousands of these people who are confronted with a future of dependency on other individuals because with a permanent disability they are unable to adjust themselves physically to the social and economic demands of our mechanized society. The compensation for living as they lie in bed, sit in a chair, or struggle to amulate a few steps, is negligible.

There are other thousands throughout the Commonwealth who are supported in their homes by the Department of Public Assistance and who are a personal burden to their family members. These people cost the taxpayers many hundred thousand dollars annually in addition to the funds spent by voluntary agencies, and prevent other family members upon whom they rely for personal service from engaging in gainful employment.

Rehabilitation Center Justified

It has been demonstrated that many of these citizens can be physically improved and vocationally prepared for employment if sent to a rehabilitation center which integrates the physical restoration, counseling and vocational services required for such rehabilitation. An institution of this type cannot be established in every community as there are not enough of these disabled in each to justify such an expenditure locally. The total

¹ Delivered at Regional Hearing in Philadelphia, Pa., August 11, 1952.

number of disabled persons throughout the entire State, however, composes a large group, large enough to justify the establishment of a rehabilitation center with specialized facilities and a combination of services designed to meet the physical, social and vocational needs imposed by various disabilities.

Surgical removal of the appendix usually relieves the patient's symptoms and restores him in a short time to full working capacity, but when a patient suffers paralysis of both lower extremities due to disease or accident, or is a victim of hemoplegia, poliomyelitis, arthritis, multiple sclerosis, neuromuscular involvements, traumatic bone and joint injuries, amputations of arms or legs, he can't return to employment upon completion of specific medical and surgical care. He requires special consideration to meet his needs and to utilize his residual functions and abilities. This can best be obtained in a rehabilitation center which provides the following services:

Services of Center

(1) Ambulation training, wheelchair operation, crutch-walking instruction, preprosthetic training, muscle reeducation and evaluation, remedial exercises, or other physical therapy modalities.

(2) Provision of braces, artificial limbs, and other types of special equipment, and instruction in their proper use and care.

(3) Special nursing service, individualized diet or other special care.

(4) Reeducation for daily living, prevocational exploration and training, vocational counseling and placement service, and occupational therapy directed towards ultimate employment.

200,000 in Pennsylvania Disabled

According to the statistics of the National Health Assembly, Pennsylvania has approximately 200,000 civilians at the present time who have been disabled as a result of an accident, congenital deformity or disease who will need rehabilitation services if they are to be successfully employed.

Thirty thousand of these are severely disabled and are unable to walk, work, or take care of themselves alone. They experience physical misery and a sense of hopelessness because they are dependent for the necessities of life upon the efforts and generosity of others. Each year this number of persons disabled increases and the annual increment is now estimated to be 4,000.

For these people to become productive members of society and again enjoy economic independence a highly individualized program of physical restoration, vocational training, and social adjustment is required. This program for total rehabilitation can be achieved only through the coordination of these services in a single institution designed specifically for severely disabled persons.

There is only one civilian rehabilitation center in the eastern part of the United States with dormitories which provides all the services required to take a severely disabled client from a state of dependency to one of independence. Such a center is known as a comprehensive center because, in addition to physical restoration and counseling, it offers a program of vocational training. This center is the Woodrow Wilson Rehabilitation Center which is operated by the Bureau of Rehabilitation in Virginia.

Wilson Rehabilitation Center

To this Center, and to those which provide only specialized rehabilitation services for the severely disabled, the Pennsylvania Bureau of Rehabilitation and the United Mine Workers Welfare Fund have sent within the past 3 years almost 2,000 residents of Pennsylvania.

The comprehensive rehabilitation center provides ideally for the concentration of varied services on a problem at the proper time and in the proper amount with a minimum of cost, inconvenience and delay. Having such services in close proximity permits workers in each specialty field to share the knowledge that others have gained of a particular client and thus establish a successful program of rehabilitation.

Evidence based on case studies indicates that, for every dollar in rehabilitation that is spent, there will be repaid over the income-producing lifetime of the rehabilitated man or woman \$10 in income taxes alone.

Furthermore, vocational rehabilitation overcomes the economic drain of dependency and low income status and conserves and salvages productive energy which would otherwise be wasted. All this adds immeasurable economic strength to the Nation as a whole. This is of special importance in times of emergency involving manpower shortage.

It is proposed that a rehabilitation center, planned and modeled after successful centers in

other States, be constructed in Pennsylvania, where it will be accessible by all types of transportation from all parts of the State and have facilities to adequately provide the specialized services required for 300 individuals. The Center will enable the Bureau of Rehabilitation to serve in Pennsylvania its severely disabled who must now be sent out of the State for this type of service.

Financing Rehabilitation

Commissioner ALBERT J. HAYES. Mr. Kefford, do you have any ideas, or do you care to express any opinion to the Commission, as to how we can accomplish these rehabilitation centers without using funds which are already designated for very important phases in the health field? Let me tell you why I ask the question. There is no doubt that rehabilitation is one of our great problems in the country. I believe it is estimated that there are nearly two million physically handicapped persons who are capable of doing useful work in our industry and business who are not now employed because we do not have the training facilities for them.

My question is: Do you have any idea as to how we might rehabilitate, train, and retrain these physically handicapped people without robbing Peter to pay Paul?

Mr. KEFFORD. Well, there was a bill proposed before Congress last year which would appropriate funds to establish throughout the United States centers and districts which would take care of, say, Pennsylvania; one would be established in Pennsylvania to provide services for citizens in Maryland and Delaware and Jersey.

And then they would set it up in regions throughout the whole United States wherein these rehabilitation centers would be established. It was proposed that Congress would appropriate the money on a State-matching basis to help construct the centers and establish the care that is needed for the severely disabled.

I do not know how else we will do it unless we take some public funds to establish these centers. It is too expensive for local communities to assume the responsibility.

Centers as Adjunct to Hospitals

Commissioner HAYES. Do you have any idea, Mr. Kefford, as to rehabilitation centers as an adjunct to existing hospitals?

Mr. KEFFORD. Well, for example, right here in Philadelphia there are physical restoration facilities which will help to restore the physical functions of clients, but there are no dormitory facilities or vocational training opportunities provided. For the severely disabled you have to have a facility which provides all the services under one roof—vocational training, physical restoration and counseling services—in order to restore these people from a state of dependency to one of independence.

Many of them are living in wheel chairs. They cannot ambulate steps, or they have braces or artificial limbs which prohibit them from using normal facilities. So that the facilities have to be built to their needs, such as at the Center—I do not know if you are familiar with the one at Woodrow Wilson.

Commissioner HAYES. Yes.

Mr. KEFFORD. That is all on one floor and the folks can ambulate all over the whole place—7 miles of corridors there that go from one place to another; they can go to the dining room; they can go to vocational shops; they can go to physical restoration facilities, and then they can make a social adjustment which helps them to return to their communities and become independent citizens.

Statement¹ of

DR. FREDERIC KOTTKE

Director

Department of Physical Medicine and Rehabilitation

University of Minnesota, Minneapolis, Minn.

Physically Handicapped Require Total Medical Care

I would like to talk to you for just a few minutes about a problem that I think is one of the major problems in the State. This is the problem of medical care for the physically handicapped people in the State of Minnesota.

Physical medicine and rehabilitation is concerned with total medical care of patients with physical handicaps.

The goal of rehabilitation is to restore the patient to the greatest physical, mental, social, vocational, and economic usefulness of which he is

¹Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

capable. When we consider environment as well, this means the restoration of the disabled person to maximal independence and productivity in his community.

1. The degree of independence which can be achieved varies inversely with the degree of disability.

The importance of this to us, as a community project, is the cost factor. It is obvious that if a patient is physically disabled and must be supported by somebody else, it is going to be very expensive to the community and to the Nation. On the other hand, if, by proper medical care, proper vocational training, and proper placement in a job, we can make that man independent in regard to supporting himself through what he produces in his job, he becomes a productive member of society, rather than merely a consumer who is dependent on the rest of society. So that is the final goal of rehabilitation.

2. However, if a patient is not restored by proper care and training to his maximal possible ability, he requires permanent assistance, which is a recurring expense far exceeding the cost of rehabilitation.

Rehabilitation Best Possible Investment

Federal Office of Vocational Rehabilitation in 1944 rehabilitated 44,000 patients at an average cost of \$293 per patient. Prior to rehabilitation the average annual income was \$148. In the year following rehabilitation the average annual income was \$1,768 for each of these patients. It is estimated that in 85 percent of the working life of these patients they will pay a Federal income tax totaling 10 times the cost of the rehabilitation services. Financially, this is the best possible investment that we can make. If we rehabilitate these people and make them independent, it is a financial investment that exceeds almost anything else we can imagine.

The physically disabled persons are those who, because of accident or disease of congenital defect, are unable, temporarily or permanently, to engage in normal living.

Just what is the problem in Minnesota has been a question asked repeatedly. The estimates—and these are only estimates—but I think they are conservative and will give you an idea of the problem we face with very inadequate facilities today—are as follows:

1. 40,000 persons are severely disabled and need rehabilitation services.

2. Among children, 3 per 1,000 are crippled and need orthopedic and rehabilitation services.

3. 11,000 children and adults have cerebral palsy.

4. 200,000 persons in Minnesota have some type of heart disease, which limits their capacity to live or to work.

5. 60,000 persons in Minnesota suffer from arthritis.

The development of an adequate rehabilitation program is a threefold problem.

The Educational Problem

First of all, there is an educational problem, the problem of training professional personnel in physical medicine and rehabilitation to take care of these people.

In rehabilitation work we have to use not a single physician, or group of physicians, but a large team of people. We need every type of medical specialty in order to take care of the manifold problems of the physically disabled. In addition to that we need the physiatrist, the man trained specially in the problems of physical disability, physical therapists, occupational therapists, social workers, vocational counsellors, and teachers of the physically handicapped.

There are far too few of these professional people available today, and there are far too few being trained, and there is no support available at the present time for expanding these training programs so that we can meet the problem adequately.

Adequate training will require the expansion of facilities of our medical schools. This is, in the first and last analysis, a medical problem, so that it is necessary that our training program be a medical school training program. This is very important and cannot be overemphasized. The total problem of the training of these people means that we must expand all of the facilities of our medical schools if we are going to be able to meet the requirements of the job.

I would like to emphasize that the rehabilitation program is a team approach. We try not to waste the patients' time; we try not to waste the patients' energy, we try to get the patient rehabilitated and into industry as quickly as possible. There is a large number of people working with the patient at one time, as a team, and it is

necessary that we train them for the team approach, centered around the medical school training so as to receive the maximum effect.

Additional Clinical Facilities

Secondly, we need additional clinical facilities, built and supported primarily to take care of the physically handicapped persons.

At the present time there are few hospital facilities available for the chronically disabled patients.

The general hospitals today are developed for the acutely ill patient, and as soon as he is over his acute illness he is discharged, and he cannot find the facilities that will provide rehabilitation care.

The general hospitals just do not have the personnel nor the facilities to provide rehabilitation services.

At the present time, when we wish to obtain vocational counseling in the State of Minnesota, our only source of trained personnel is the Minnesota Division of Vocational Rehabilitation, and this Division is far too small and has far too few workers and counsellors to give us the assistance we need in the testing and counselling of disabled persons. Consequently, they can scarcely begin to take care of the problems we have within this State.

Patients Can't Finance Rehabilitation

Finally, I would like to point out that the physically handicapped patients are not eligible for medical care under the various insurance programs for their major disability. For most of these patients there is no means of financing ade-

quate rehabilitation services. Consequently, they cannot obtain rehabilitation, even when it means that they would be independent at the end of their rehabilitation period.

Then the third phase of rehabilitation involves research in order to develop better methods of rehabilitation—so that we can shorten the period of treatment and improve the results. This involves more research facilities within the medical schools in order to provide the staff to study the problems of making these people independent.

At the present there are few facilities or investigators, and very little support for fundamental or applied research in rehabilitation.

Adequate laboratory facilities must be made available to study the effect of disability on efficiency and productivity, and also to study means of improving efficiency of patients with the various disabilities.

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Commissioner DEAN A. CLARK. Do you have a rehabilitation center at the University?

Dr. KOTTKE. We have a rehabilitation center at the University.

Commissioner CLARK. Are there any others in the State, as yet?

Dr. KOTTKE. They have a rehabilitation center at the Mayo Clinic in Rochester. Our center, however, does not have any program for training vocational counsellors. It has an inadequate program for training teachers for the disabled, and we do not train nearly enough physical therapists or occupational therapists to meet even the needs in Minnesota.

Rochester does not have a training program, except for physical therapists and physicians.

NUTRITION

Statement¹ by

DR. BERTLYN BOSLEY

**North Carolina Home Economics Association
Raleigh, N. C.**

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Trained home economists working in health, welfare, agriculture, and education agencies and organizations and in homes throughout the Nation

are dedicated to improving home and family living. As in many other areas, the need for services exceeds the number of adequately trained personnel in the established agencies.

Premises in Health Evaluation

Home economists in North Carolina accepted the following premises in evaluating the health needs of the State, namely, that:

1. The primary essentials for securing and maintaining good health are food, shelter, clothing, personal health, health services;

¹ Delivered at Regional Hearing in Raleigh, N. C., August 25, 1952.

2. These minimum essentials are not equally available to all persons;

3. Adequate provision of the first three—food, shelter, clothing—to all persons would have a significant influence upon the amount and kind of health services needed;

4. Prevention of the development of health problems resulting from inadequate food, shelter, and clothing would make it possible to extend even limited health services.

5. The health needs of the Nation are met only as health needs of each individual member of society are met.

On the basis of the above premises there is need for a correction of some of the obvious deficiencies among certain population groups in the South, if fundamental health needs are to be met. Primary needs should be attacked first. Among these the deficiencies existing in nutrition should have priority.

Dietary Inadequacies

The South is fortunate in having a long growing season, thus making it possible to supply large quantities of food for its resident population and for other areas of the Nation. Despite this regional food production advantage, dietary studies among white and Negro sharecroppers in Mississippi, made by the Department of Home Economics, Mississippi Agricultural Experiment Station, report dietary inadequacies, especially among such food groups as milk and milk products, eggs, green leafy and yellow vegetables, tomatoes and citrus fruits.

A 5-year study of dietaries of a large sample of 9 to 11 year-old white and Negro school children was made in North Carolina by the Nutrition Section of the State Board of Health. In this survey of children, representing all income levels, green leafy and yellow vegetables, tomatoes and citrus fruits and milk were most often lacking in the diets. Cereals, potatoes, meat and eggs were the more common articles of diet.

A third study made in North Carolina by the State Board of Health and the State Board of Welfare among approximately 1,000 families receiving aid to dependent children funds gives almost the same kind of picture.

* * * * *

Inadequate Milk Consumption

The lowest intake is in milk Milk is inadequately consumed in the Piedmont section

by both white and Negro groups. Vegetables come next, fruits third, and the dried beans and peas, which we find so commonly used, still are relatively low. Our meat and eggs, however, are nearer the fruit.

The condition in the coastal area . . . is a little worse than it is in the Piedmont section. That, of course, we would expect, because of the type of agriculture which we find in the eastern section. But I would call your attention to the amount of milk consumed by these families, on a percentage basis, in the coastal plain areas. I would like also to have you remember that the diet used here was the minimum diet—the very lowest economic level diet—which we could possibly imagine would provide an adequate diet for the people.

The studies illustrate that there exists in the South groups of people subsisting on nutritionally deficient diets; that the foods which are most frequently omitted from the diets are those which are known to be essential to good growth and development of children and for the maintenance of health in individuals of all ages.

Access to Food Required

Adequate diets for health can be supplied when each individual has access to the food his body needs to help develop and maintain it to its fullest potential. To bring this about, we would like to make the following suggestions:

1. Education of individuals in a manner which will (a) encourage them to apply the knowledge which exists about the role of food in the body; (b) help individuals and families to secure the best possible diets on limited income.

2. Emphasizing the importance of vegetable gardens, chickens and cows for all families in rural areas.

3. Abandoning the practice of using all available land for money crops, while omitting space for family gardens.

4. Abandoning the practice of depriving the family of sufficient amounts of garden and farm products because these products serve as a source of income.

5. A source of sufficient funds to secure adequate diets for those families who cannot produce food.

Poor diets are the result of (1) established food habits of several generations that resist improvements; (2) lack of knowledge about the impor-

tance of food for good health; (3) lack of opportunity or desire to produce food; (4) lack of money.

National, State, and local leaders need to appreciate fully the function of food in the maintenance of good health and recognize the resulting poor health which may be influenced by long-term dietary deficiencies.

Housing Important

In addition to food, shelter also is a vital factor in the maintenance of health. Housing facilities, including water, sanitation, light, heat, and ventilation, are important in the protection of the health of individuals. Studies have shown a relationship between illness and mortality and the quality of housing facilities. For example, as the quality of housing decreases, infant mortality rates increase.

Rural Families

The North Carolina Home Economics Association wishes to go on record as recognizing the need for better health services to all rural families, including tenant and Negro groups, but it wishes to insist that particular attention be given to preventive measures, such as those listed, in order to reduce the need for medical care which the lack of basic health essentials creates.

Middle Income Group

It also wishes to point out the need for supplying adequate health and medical service for the middle income segment of the population. The cost of medical services is now so high that this group of people frequently does not seek medical advice early; and when medical attention is imperative the group finds that essentials—food and shelter—must be sacrificed to pay for such services. This group, capable of supporting itself under normal circumstances and not eligible for any type of public assistance, is often overlooked in an evaluation of health needs.

The Association recognizes the fact that no amount of money or services will solve the problems unless they are utilized to the best advantage. The health needs of persons residing in any section of the country can be met only as the people become aware of the advantages of better health.

Developing this awareness among certain population groups has been difficult. Success in our efforts will require personnel who possess the ability to assist others in applying—in a practical

fashion—the growing scientific knowledge available for the development and maintenance of good health.

Statement¹ of

MRS. FLORENCE SCOTT

Nutrition Consultant

Minneapolis Health Department

Family and Children's Service

Minneapolis, Minn.

Since Minnesota and her neighbors are agricultural states, many people feel that they have few nutritional problems. Actually, the results of research in this area show that there are many serious nutritional problems which merit attention, which is not received because of the lack of trained nutritionists. This lack is due not to temporary shortages in personnel, but rather to the fact that few positions have been created. Although it is usually recognized that nutritionists are needed as a necessary part of the public health team, the reason given for the lack of positions is lack of funds or allocation of available funds to other programs.

In the entire State of Minnesota there are only seven public health nutrition positions; two are in State-wide positions, one in a county health unit which has been unfilled, and four with voluntary agencies. If you add to this the 4 home economists working with State, county, and voluntary social welfare agencies, you have a total of 11. We need many more than this.

Reasons Nutritionists Needed

Here are some of the reasons why they are needed:

1. Nutritionists are needed to help carry out a program of nutrition education with expectant mothers if our high death rates from toxemias of pregnancy—the cause of 36.4 percent of all our maternal deaths in Minnesota, according to the Department of Health—are to be reduced. Better nutrition for pregnant mothers would also help to reduce the death rate from premature birth—8 of the 10 leading causes of all deaths in Minnesota.

Diet surveys of pregnant mothers in Minnesota and Iowa show that their diets are not adequate for the best development of the infant and health of the mother. The nutrition of the mother dur-

¹ Delivered at Regional Hearing in Minneapolis, Minn., September 2, 1952.

ing the prenatal period affects both the mother and fetus. According to carefully controlled clinical studies, it has been shown that if the mother's nutrition is inadequate, she is more likely to have a toxemia. Also, there are more prematures, stillbirths, and infant deaths in the poor diet group.

Such evidence demonstrates that these losses come from conditions largely preventable rather than curable. It is important not to wait until after the accident has happened before attention is given. More emphasis must be placed on better nutrition for expectant mothers. Well trained public health nutritionists are needed to assist in this educational work. They might serve in State or local public health units or in out-patient departments of State, county, or city hospitals.

Nutrition Education Neglected

Hospitals and clinics as they are organized at present are not meeting the existing need for nutrition education.

In a survey conducted in 25 hospitals located in Minneapolis, St. Paul, Rochester, and Duluth, it was brought out that in only four were dietitians giving instruction to maternity patients, and then only for special diet purposes. In only one hospital were lactating mothers given instruction in normal nursing diet needs—and that was provided by a public health nutritionist. Diet histories were taken in seven hospitals under certain conditions such as for case studies or special diets. In only five did the dietitian counsel pediatric patients (or patient's mother) about a child's diet.

Community Nutrition Programs

2. Nutritionists are needed to conduct community programs for the improvement of food habits among the whole population.

Several consumption studies have shown that the food habits of children and youth in our area are far from satisfactory. An extensive study of the diets of school children in the upper midwest, including more than 5,000 in Minnesota, which was conducted between 1948 and 1950, showed that only 37 percent of the diets of these children were rated good; that is, they supplied 80 percent or more of the recommended amounts of the essential nutrients; 29 percent were fair—they supplied 60 to 80 percent of essential nutrients; and one-third (34 percent) were rated poor, supplying less than 60 percent of the recommended amounts of essential nutrients.

The adolescent boys and girls had even poorer diets than the younger school children. Since the adolescent years are years of rapid growth and development, it is particularly serious that this downgrading of diets should occur.

* * * * *

Vitamin Deficiencies in Children and Adults

Dr. Charles May of the University of Minnesota . . . said that "Examinations of tissues at autopsy indicate that one-fourth of all infants dying from all sorts of conditions are receiving inadequate Vitamin C, as revealed by early lesions in the bones. Vitamin D deficiency is also frequently encountered."

Every effort should be made to overcome this health handicap by better nutrition education in schools, both public and parochial. It should include programs for parents, including parents of preschool children. It should be integrated with well-child conferences and other programs promoting better health for children of all ages.

Nutrition programs with adults are also needed. Improvement of day to day food habits would help to prolong and enrich the lives of our adult citizens, many of whom are overweight or suffering from other serious degenerative diseases which depend for improvement on more intelligent use of food.

School Lunch Program

3. Nutritionists are needed to assist with the Community School Lunch Program. . . . Observations on the part of nutritionists have disclosed the fact that in menus offered to children there is often lack of protein and other protective foods resulting in inadequate lunches. Due to lack of scientific information on the part of lunchroom personnel on proper methods of food preparation, serving, and storage of food supplies, there is also waste of the nutritive value of food.

Nutrition in Dental Health

4. Nutritionists are needed to assist with the dental health program.

Another evidence of inadequate nutrition and poor food habits among Minnesota children is the high incidence of dental caries. Although there is some variation among communities, the average 16-year-old child in Minnesota has 15 decayed, missing or filled permanent teeth, a situation which leaves much to be desired.

A diet adequate in all nutrients is essential during the period of tooth formation to assure sound teeth and good supporting structures. After the teeth have formed the greatest single dietary factor conducive to caries formation appears to be sugar, and the greatest dietary factor preventing caries formation is fluoride. Increasing effort should be made to prevent and/or control this problem of caries by emphasizing an adequate diet with the elimination of excessive sweets and the enrichment of water with fluoride, where the content is below a satisfactory level.

Funds to assist State, county, and city agencies should be provided to permit them to meet the challenge of these and other serious nutritional problems.

Statement¹ of

MISS ELIZABETH WHIPPLE

**The Nutrition Association
Cleveland, Ohio**

In a large industrial city such as this, one would assume offhand that there was no problem in a period of high employment and high salaries.

We have made a number of surveys of school children's meals and of the food eaten by expectant mothers. In the case of school children's meals we find that at least two of the important food groups are not eaten in adequate amounts by half the children or less. In a survey of expectant mothers we discovered among other things that only 20 percent of the pregnant women had an adequate amount of milk, meat and eggs, which all current research shows is most important to the health of the baby as well as the mother.

* * * * *

Application of Recent Knowledge

Although the science of nutrition has grown by leaps and bounds in the last generation, there is still a wide gap between what we know about nutrition and its application by the general public. The work of the Public Health Nutritionist helps to close that gap. The reason we work with other public health workers is that some, but not all public health workers have the benefit of recent training in nutrition and of access to current reports.

Some, but not all public health workers, have the knack of translating technical nutrition facts into practical terms.

So the public health worker helps other people keep up to date and down to earth in their nutrition teaching. The demand for nutrition consultants far exceeds the supply. For example, the Nutrition Association has spent literally months—and I hate to tell you how many months—trying to fill a staff position that carries adequate salary. Other agencies have exactly the same experience.

Well-Trained Nutritionists Scarce

Many agencies do not budget for nutritionists because it is so difficult to find well trained ones. At one time recently there were 50 budgeted but unfilled positions for nutrition consultants—not people who work directly with the lay public but who work with professional people. There were 50 budgeted but unfilled positions at the State level, and nobody knows how many more in the cities and voluntary agencies.

In this five-city area only one City Health Department has a trained nutritionist on its staff. The Nutrition Association, with a small staff of three, offers what service it can to these other health departments, along with its services to privately supported agencies in this large area.

Teachers usually have no training in nutrition and no training in how best to teach it. Yet they have our future citizens in their most trainable period.

Teachers Need Help

Teachers need help in both what to teach and, overworked as teachers are these days, in how to teach it.

We have a program here that consists of weaving the teaching of good food habits into reading, writing, and arithmetic, history, geography, and science. Surveys show that large percentages of children are not eating enough of the important food even when money is not the problem. We know this for most of these surveys show that meat consumption is more adequate than the consumption of any other food. Since meat is the most expensive food, it obviously means that something else besides cost is the difficulty in children not having food they need for the most vigorous health.

¹ Delivered at Regional Hearing in Cleveland, Ohio, September 22, 1952.

In regard to the adequacy of medical research in nutrition, almost everybody agreed from clinical experience that nutrition has a fundamental relationship to disease and health in later years; but research studies are greatly needed for practical methods of preventing chronic diseases that take a high toll in manpower.

Nutrition in the Aged

No one needs to be reminded again of our aging population, but we do need to be told through nutrition research more definitely how nutrition research in the early years can make the later years more fruitful and independent.

BLOOD BANKS

Statement¹ by

JOHN R. UPTON, M. D.

Chairman

California Medical Association

Blood Bank Commission

San Francisco, Calif.

The California Blood Bank System

The population of California is approximately 11,000,000. There are approximately 42,000 hospital beds in the State. Computed at a minimum of 5 units of blood per hospital bed per year, this would require a total of 210,000 units of blood annually.

In California at this time there are 11 medically sponsored community blood banks; 3 Red Cross regional blood centers; 22 hospital blood banks; and 5 commercial blood banks.

This report will be confined to the functions of the medically sponsored, nonprofit, community blood banks, which is known as the California Blood Bank System, a unique American blood-bank plan.

It was here in California in 1941 that organized medicine first began to sponsor this type of blood bank program, and today there are 11 of these banks in operation, from the northern to the southern boundaries, situated in the eastern and western parts of the State.

These blood banks function on the philosophy that patients receiving blood transfusions pay a cost service (maintenance) fee and have a financial responsibility to provide a donor replacement for each unit of blood used. No one is ever refused service due to inability to meet these requirements.

System Meets Civilian and Military Needs

All blood needs are met in our communities. Through peace and war our system has met its obligations to provide transfusion service to civilian and military patients alike, and we have been able to perform this service for the following reasons:

1. With our civilian replacement plan our blood banks are solvent in blood at all times, and they are financially sound. We do not have to resort to emotional appeals to the public for our blood banks to keep their refrigerators stocked with blood to meet civilian needs. In 1951, our California Blood Bank System distributed a total of 125,000 units of blood at cost for the day-by-day civilian needs.

2. When donors give blood for the defense program in our banks, the military receive the blood. In peace we prepared for disaster or war—we were ready when the Korean War occurred and immediately started shipments of blood to the Far East. Since the Korean War started we have delivered to the armed services through the Red Cross a total of 327,899 units of blood at cost or at an average of \$5.08 per unit.

Our system banks have delivered to the armed services 61 percent of all the blood drawn by the Nation's independent community banks. San Francisco ranks third in the Nation for all banks drawing blood for the national defense blood program. Per capita, the people of the San Francisco and Northern Bay areas have given more blood than any other area in the United States.

3. There is a "grass roots" pride amongst physicians and community residents who support and guide the operation of their blood bank program.

"California Life Line"

4. Our widely dispersed blood banks are coordinated and integrated in a "California Life

¹ Delivered at Regional Hearing in San Francisco, Calif., September 29, 1952.

Line" to prevent any blood shortage within the system.

5. Through enlightened and courageous efforts, the California Medical Association, by its far-sightedness:

a. Created a Blood Bank Commission of seasoned and experienced voluntary doctors to advise and assist local communities and local county medical societies to create their own blood banks.

b. Provides matching loans for the establishment of nonprofit banks.

6. Creation and operation of the first clearing house for blood banks in the country. This clearing house inaugurated a business system of blood keeping. Its functions are to:

a. Integrate all blood bank activities.

b. Maintain current records of all blood available in our State system.

c. Spot-check rare types of blood and protect those who need such rare types by making the blood available in the right spot at the right time.

d. Act as the control center for the actual exchange of blood or blood credits or debits between member banks within the State of California and the widely separated banks of the Nation with whom our system has reciprocity.

e. Act as the agent for the purchasing of supplies so that by mass buying the cost to the individual bank, and therefore to the recipient of blood, can be lessened.

f. Encourage blood training programs and indoctrination of new administrative and technical personnel.

g. Disseminate publicity pertaining to the "Life Line." Inculcate and then support the community to provide for their own needs—Be self-reliant.

h. Encourage and assist a realistic research program.

"Grass Roots" Blood Bank Program

The California Blood Bank System recommends to the President's Commission that to be successful, any local, State, or integrated national blood bank program must be predicated on blood solvency and financial self-support. This basic fact is particularly true for a long range realistic civilian program.

Such a plan should be nonprofit but self-supporting, medically sponsored and community-shared. A healthy respected "grass roots" blood bank program such as ours will meet the demands of our Nation in peace or in disaster.

We cite Paul de Kruif's article in the August issue of *Reader's Digest*, entitled "California's Blood Brotherhood." This is our Blood Story.

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